ADVANCED SPINAL HEALTH, LLC
Optimizing Your Health Through Chiropractic and Nutrition

Steven Salyers DC MS CNS DACBN

Patient Information Date: _____

Last Name: _____ First Name: _____ M.I. _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Would you like appointment reminders? Y N Four Digit Pin for Check-In: ____ - ____ - ____- ____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed SS#: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

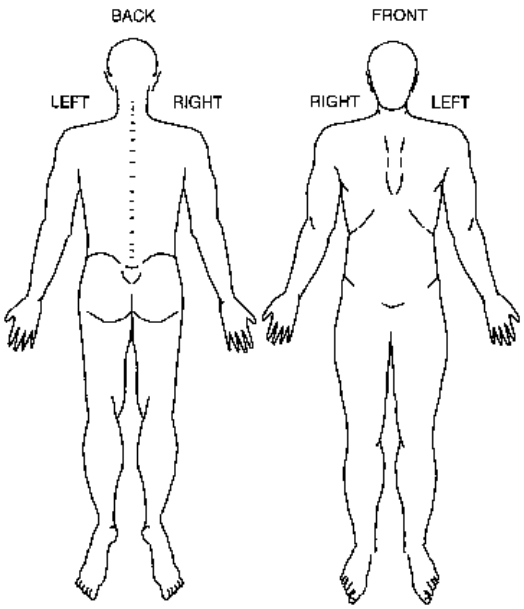
Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____

Please check the kind of care desired: ☐ Temporary Relief ☐ Corrective Care

Who may we thank for referring you? _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also, describe the frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc.



Major Complaints: _____

_____

Was this the result of an accident? Y N Date of Injury: _____

If injury, describe injury: _____

When did your current symptoms begin?

_____

Have you ever had this problem or similar problem before?

_____

Have you received any treatment for this condition? Y N

Explain: _____

Any recent imaging? If so, date and location: _____

_____

The problem has been: ☐ getting better ☐ getting worse ☐ staying the same

PLEASE COMPLETE THE REVERSE SIDE

Is there anything you do that makes your condition worse? Y N Explain: _____

_____

Have you had surgery or been hospitalized? Y N If yes, when? _____ Place: _____

What was your surgery/hospitalization for? _____

Do you exercise regularly? Y N Explain: _____

Are you presently being treated for any medical problems or diseases? Y N Explain: _____

_____

Have you ever been treated by a chiropractor? Y N Explain: _____

Name of chiropractor who last treated you: _____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Prescriptions you are presently taking: ☐ Anti-Inflammatory ☐ Pain Meds ☐ Muscle Relaxers

☐ Anti-Depressants ☐ Sleep Meds ☐ Diabetes ☐ Hormones ☐ Antacids

☐ Other, please list: _____

Any family history of cancer? Y N Explain: _____

Primary Insurance Information

Company: _____ ID#: _____

Subscriber Last Name: _____ First: _____

Relationship to Subscriber: _____ Subscriber DOB: _____

Secondary Insurance Information (If Applicable)

Company: _____ ID#: _____

Subscriber Last Name: _____ First: _____

Relationship to Subscriber: _____ Subscriber DOB: _____

Accident Information (If Applicable)

Did your accident occur at work? Y N Were you involved in an auto accident? Y N

(Please tell the front desk, if you answered yes to any of these questions)

Attorney Name: _____ Phone: _____

If yes to either, Date: _____ Time: _____

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that an interest fee at 12% per annum will be charged as well as a $10 late fee per month on any balance over 90 days. I agree to pay for all fees incurred, and in any event of default, agree to pay reasonable collection fees charges and/or attorney fees. I further understand that if I suspend or terminate my care and treatment, any fees will be immediately due and payable.

Patient Signature: _____ Date: _____