



- Patient History Form

**ADVANTACARE Chiropractic and Wellness Center**

2608 Ring Road, Suite 200

Elizabethtown, KY 42701

Telephone (270)769-2255 Fax (270)763-9773

Email address: [info@advantacarechiropractic.com](mailto:info@advantacarechiropractic.com)

**Office Hours:** (call for availability)

- Monday: 8:00-6:00
  - Tuesday: Emergencies / By Appointment ONLY
  - Wednesday: 8:00-6:00
  - Thursday: 2:00-5:00
  - Friday: 8:00-12:00
  - Saturday Closed
  - Sunday Closed
- \*Hours of operation subject to change without notice

**Important Notice**

Please fill out the following forms as completely as possible and bring them, along with your "**Insurance Card**" and a "**Photo ID**" to our first visit.

If you have any questions, please do not hesitate to call (270) 769-2255

# PATIENT HISTORY

What do you prefer to be called: \_\_\_\_\_  
Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_ (MI) \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: ____/____/____ Patient Social Security # ____ - ____ - ____	Your Age: _____ Married Single Divorced Widowed
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Home phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Patient's Employer: \_\_\_\_\_ Retired Unemployed Student  
Employer's Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_  
Spouses Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Spouse's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_  
Name of Person Responsible for this account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Do you have children? Yes / No How many? \_\_\_\_\_ Ages of Children: \_\_\_\_\_

### IN EVENT OF EMERGENCY

Who should we contact? \_\_\_\_\_ Relationship to You: \_\_\_\_\_  
Home Ph: #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Alt. Ph: #: ( ) \_\_\_\_\_ - \_\_\_\_\_

**PAIN INTENSITY:** Please put a **STAR** on the scale describing the intensity of your pain **RIGHT NOW:**

No Pain 0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ 8 \_\_\_\_\_ 9 \_\_\_\_\_ 10 Unbearable Pain

### CONFIDENTIAL HEALTH HISTORY

*Please feel free to use the back of this form to provide additional information*

Have you ever had surgery or been hospitalized? Yes / No **List Surgeries:** \_\_\_\_\_

Please list any past serious accidents, injuries, or motor vehicle accidents with dates: \_\_\_\_\_

Please list any medications or vitamins you are currently taking: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

Do you have, or have you ever had any of the following health problems? **(Check all that apply)**

- |  |   |  |  |
|--|---|--|--|
| ____ Headaches<br>____ Migraine<br>____ Neck Pain / Stiffness<br>____ Shoulder Pain / Stiffness<br>____ Numbness / Tingling Arm(s)<br>____ Elbow Pain / Stiffness<br>____ Wrist / Hand Pain or Stiffness<br>____ Upper Back Pain or Stiffness<br>____ Mid Back Pain or Stiffness<br>____ Low Back Pain or Stiffness<br>____ Hip Pain or Stiffness<br>____ Knee Pain or Stiffness<br>____ Ankle/Foot Pain or Stiffness<br>____ Pain shooting down leg(s)<br>____ Trouble Walking<br>____ Sore Muscles<br>____ Painful Joints<br>____ Tiredness / Fatigue<br>____ Other Problems not listed: _____ | ____ Achyness / General Pain<br>____ Difficulty Concentrating<br>____ Memory Loss / Forgetful<br>____ Frequent Colds / Flus<br>____ Nervousness<br>____ Irritability<br>____ Diabetes<br>____ Cancer<br>____ Vision / Eye Problems<br>____ Hearing / Ear Problems<br>____ Ear Infections<br>____ Sinus Problems<br>____ Thyroid Problems<br>____ Allergies<br>____ Asthma<br>____ Trouble Breathing<br>____ Heart Problems<br>____ Circulation Problems | ____ High / Low Blood Pressure<br>____ Excessive Sweating<br>____ Stomach Problems<br>____ Nausea<br>____ Ulcers<br>____ Liver / Gall Bladder Problems<br>____ Kidney Problems<br>____ Digestion Problems<br>____ Diarrhea<br>____ Constipation<br>____ Bladder Problems<br>____ Incontinence<br>____ Impotence<br>____ Prostate Problems<br>____ Bed Wetting<br>____ Menstrual Problems (PMS)<br>____ Fractured Bones<br>____ Dizziness | ____ Auto Accidents<br>____ Other Accidents/ Falls<br>____ Sports Injuries<br>____ Work Injuries<br>____ Fainting<br>____ Depression<br>____ Mood Disorders<br>____ Emotional Disorders<br>____ Tension<br>____ Stress<br>____ Anxiety<br>____ Poor Diet<br>____ Pain w/ coughing<br>____ Pain w/ sneezing<br>____ Pain at stools<br>____ Restricts Daily Activity<br>____ Restricts Exercise<br>____ Unable to Work |
|--|---|--|--|

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_