ADVANTACARE
CHIROPRACTIC WELLNESS CENTER

Patient Name: _____ Date: _____

Chiropractic ~ Application for Patient Care

PATIENT INFORMATION

First Name: _____ M.I.: ____ Last Name: _____ Gender M / F

SS#:_____-_____-_____ Driver's License #: _____

What do you prefer to be called? _____ DOB: __ __ /__ __ /__ __ Age: _____

Address: _____ City/State/Zip: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

Email: _____@_____ Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name: _____ Spouse's Occupation: _____

Do you have children? ____Yes ____No # of Children? _____ Children's Ages: _____

Is there anyone else in your family, a loved one or friend that could benefit from our care? _____

EMPLOYMENT

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Volunteer ☐ Other

Business Name: _____Occupation / Job Title: _____

Business Phone: (_____) _____-_____ Is it okay to contact you at work if necessary? ____Yes ____No

Type of Tasks Performed/Common Movements: _____

EMERGENCY

Emergency Contact Name: _____ Relationship to you: _____

Address: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____Phone #:_____

Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

ACCIDENT

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received: ☐ Physical Therapy ☐ Chiropractic Care ☐ Pain Management? Last Visit: _____

REFERRALS

How Did You Hear About This Office?

☐ Existing Patient: _____ ☐ Other: _____

☐ Newspaper: _____ ☐ Internet: _____

☐ Employee Referral: _____ ☐ Community Event: _____

☐ Physician Referral: _____ ☐ Phone Book: _____

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Member ID/Policy #: _____ Group #: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

Member ID/Policy #: _____ Group #: _____

PRIMARY INSURED: All of the following information is about the INSURANCE HOLDER

Name of Insured: _____ DOB of Insured: ____/____/_____

Relationship to you (the patient):_____ Employer: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Signature (X) _____ Date_____

ADVANTACARE Chiropractic Wellness Center 2902 Dolphin Drive Elizabethtown, KY 42701
Dr. Craig A. Bartelt PH: 270.769.2255 Fax: 270.763.9773

ADVANTACARE
CHIROPRACTIC WELLNESS CENTER

Patient Name: _____ Date: _____

PRIMARY COMPLAINTS: Please list in order of most severe (#1) to least severe (#4). *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.*

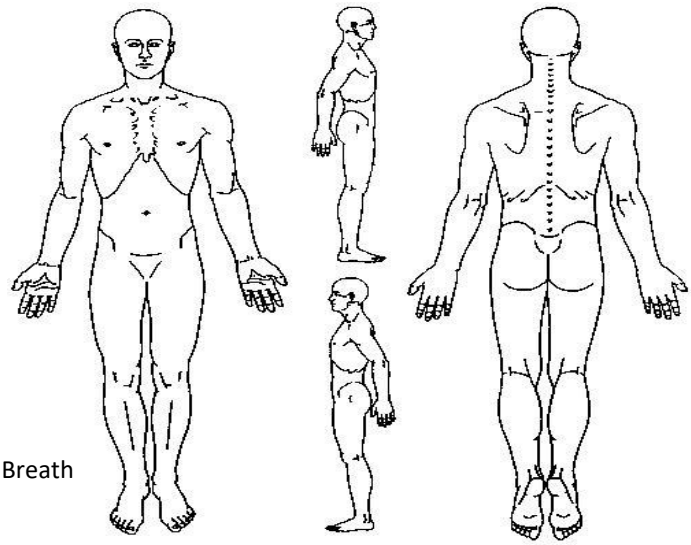
MOST SEVERE ◄——————————► **LEAST SEVERE**

You have the following complaints (WRITE-IN)	**1.**	**2.**	**3.**	**4.**
Circle the word that best describes this complaint.	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other
How often do you feel this complaint?	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"
How long have you had this complaint?	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better, if anything?				
What makes it worse, if anything?				
On a scale of 0 – 10, rate your discomfort. *(0 = no pain, 10 = excruciating)*	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life. *(all that apply)*	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: *(Circle best response)*	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

PATIENT HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Loss of Taste
- ❑ Nervousness
- ❑ Jaw Problems
- ❑ Loss of Smell
- ❑ Blurred/Double Vision
- ❑ Mood Changes
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weigh Change
- ❑ Loss of Memory
- ❑ Cold Extremities
- ❑ Sleeping Difficulties
- ❑ Bowel/Bladder Changes
- ❑ Constipation/Diarrhea
- ❑ Swollen Joints
- ❑ Trouble Concentrating
- ❑ Nausea
- ❑ Night Pain
- ❑ Fatigue
- ❑ Fever
- ❑ Tension
- ❑ Chest Pain
- ❑ Asthma
- ❑ Cold Sweats
- ❑ Dizziness
- ❑ Fainting
- ❑ Stomach Problems
- ❑ Foot Trouble
- ❑ Loss of Balance
- ❑ Shortness of Breath



ADVANTACARE Chiropractic Wellness Center 2902 Dolphin Drive Elizabethtown, KY 42701
Dr. Craig A. Bartelt PH: 270.769.2255 Fax: 270.763.9773

ADVANTACARE CHIROPRACTIC WELLNESS CENTER

Patient Name: _____ Date: _____

PATIENT HEALTH HISTORY continued....

Please check if you have ever had any of the following:

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Ankle Pain/Stiffness
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low (circle)
- ❑ Breast Lump
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Circulation Problems
- ❑ Colon Trouble
- ❑ Concentration Prob
- ❑ Contacts/Glasses
- ❑ Degenerative Disc
- ❑ Depression
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Dry Skin
- ❑ Ear Infections
- ❑ Elbow Pain / Stiff
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Fatigue
- ❑ Fractures
- ❑ Frequent Colds & Flu
- ❑ Gall Bladder
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Hand/Wrist Pain
- ❑ Headaches
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hip Pain/Stiffness
- ❑ Hip/Knee/Shoulder Replacement
- ❑ Hormone/Gland Problems
- ❑ Implanted Device
- ❑ Inadequate Water Intake
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Knee Pain/Stiffness
- ❑ Liver Disease
- ❑ Low Back Pain/Stiff
- ❑ Mid Back Pain/Stiff
- ❑ Upper Back Pain/Stiff
- ❑ Measles
- ❑ Menopausal Prob.
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mouth Sores or Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nose/Sinus Problems
- ❑ Nosebleeds
- ❑ Numbness/Tingling Arm
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pain with stools
- ❑ Pain Radiating – Arm
- ❑ Pain Radiating – Leg
- ❑ Pain w/coughing
- ❑ Pain w/sneezing
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Poor Diet
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexual Difficulty
- ❑ Shingles
- ❑ Shoulder Pain / Stiffness
- ❑ Spinal Surgery
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Throat Problems
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tonsillitis
- ❑ Tremors
- ❑ Trouble Walking
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Genetic Disorder: _____
- ❑ NONE

❑ Other Disorder/Disease/Device/Implant/Surgical Hardware or Medical Condition not mentioned above:_____

Do any of the above health conditions restrict your daily activities? ❑ Yes ❑ No If yes, explain _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any and all medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

ALLERGIES: (Please place a check mark next to any known allergy that you have.) ❑ I have no known allergies

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine
___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen
___Insects ___Latex ___Dog Dander ___Cat Dander ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease _____ ❑ Diabetes _____ ❑ Other _____
❑ Cancer _____ _____ ❑ Arthritis _____ _____

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes _____ pks/day

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.

Signature (X) _____ Date_____

ADVANTACARE Chiropractic Wellness Center 2902 Dolphin Drive Elizabethtown, KY 42701
Dr. Craig A. Bartelt PH: 270.769.2255 Fax: 270.763.9773