Welcome to Our Office

AMERICARE HEALTH & REHAB CENTER, P.C.

Last Name: _____ **First Name:** _____ **M.I.** _____
Address: _____ **City:** _____ **State**___ **Zip:** _____
Phone/Home: (____) _____ **Phone/Work:** (____) _____
Date of Birth: _____ **Social Security #** _____
E-Mail Address: _____ **Referred** _____
Dominant Hand: ❑ **Right** ❑ **Left** ❑ **Both** **Marital Status:** ❑ **S** ❑ **M** ❑ **D** ❑ **W**
Employer: _____ **Occupation:** _____ **How Long?**_____
Employer's Address: _____
City: _____ **State:** _____ Zip: _____

INSURANCE INFORMATION:

We will need to copy your **Insurance Card** and **Driver's License** for our records.
Date of Injury/Illness or when did your symptoms first appear: _____
Have you ever been treated by a Chiropractor before: ❑ **Yes** ❑ **No**
Have you ever had Acupuncture: ❑ **Yes** ❑ **No**
The reason for this visit is a result of (Please Check) ❑ **Work** ❑ **Sports Injury** ❑ **Auto**
❑ **Trauma** ❑ **Chronic Pain**
How will you be paying for this visit: ❑ **Cash** ❑ **Credit Card** ❑ **Insurance**

What You Are Seeking Treatment For:

Enter a full description of the problem you are seeking treatment for and how it happened or started.
Please Print

Are you currently taking **vitamin/mineral** supplements?
❑**Yes** ❑ **No** If so, please list all that you are taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

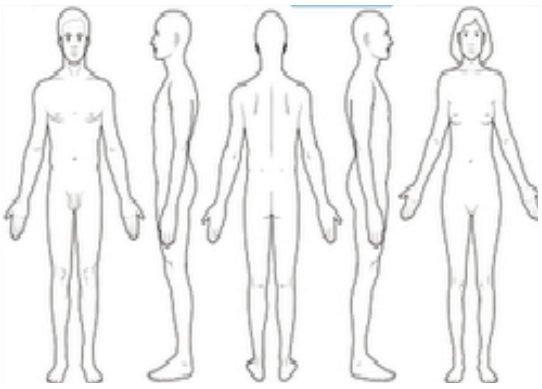
Are you currently taking **medications**? ❑**Yes** ❑ **No**
If so, please list all that you are taking:

❑ **High Blood Pressure Medication** ❑ **Diabetic Meds**
❑ **Cholesterol Meds.** ❑ **Muscle Relaxants**

_____ _____
_____ _____
_____ _____

❑ **Aspirin** ❑ **Birth Control Pills** ❑ **Nerve Pills**
❑ **Pain Killers .** ❑ **Blood Thinners** ❑ **Antacids**
❑ **Thyroid Meds.** ❑ **Tranquilizers**
❑ **Other:** _____

Please indicate the areas of pain or discomfort or the point(s) of injury on the appropriate diagram below



How often do you experience your symptoms?
❑ Constantly - 76 - 100% of the day
❑ Frequently - 51 - 75% of the day
❑ Occasionally - 26 - 50% of the day
❑ Intermittently - 0 - 25% of the day

Severity Scale: On a scale from 1 to 10 - 10 being at it's worst. How bad are your symptoms today?
NONE 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. UNBEARABLE

Health History

For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past. If you currently have a condition check the PRESENT column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
❑	❑	Heart Attack / Stroke	❑	❑	Pacemaker	❑	❑	Arrhythmia
❑	❑	Diabetes	❑	❑	Alcohol/Drug Abuse	❑	❑	Arthritis
❑	❑	Headaches	❑	❑	High Blood Pressure	❑	❑	HIV + AIDS
❑	❑	Neck Pain	❑	❑	Low Blood Pressure	❑	❑	Fainting
❑	❑	Upper Back Pain	❑	❑	Sinus Problems	❑	❑	Digestive Disorders
❑	❑	Mid Back Pain	❑	❑	Emphysema	❑	❑	Lower Back Pain
❑	❑	Blood Clots	❑	❑	Asthma	❑	❑	Tumor
❑	❑	Joint Swelling/Stiffness	❑	❑	Dizziness	❑	❑	Difficulty Breathing
❑	❑	Elbow Pain	❑	❑	Heart Surgery	❑	❑	Epilepsy
❑	❑	Upper Arm Pain	❑	❑	Cancer	❑	❑	Venereal Disease
❑	❑	Wrist Pain	❑	❑	Rheumatic Fever	❑	❑	Ulcers
❑	❑	Ankle Pain	❑	❑	Hepatitis	❑	❑	Cold Extremities
❑	❑	Hand Pain	❑	❑	Anemia	❑	❑	Glaucoma
❑	❑	Sciatica	❑	❑	Artificial Valves	❑	❑	Excessive Thirst
❑	❑	Hip Pain	❑	❑	Chemotherapy	❑	❑	Bladder Infection
❑	❑	Upper Leg Pain	❑	❑	Kidney Problems	❑	❑	Prostate Problems
❑	❑	Numbness-Hands/Feet	❑	❑	Shingles	❑	❑	IBS
❑	❑	Foot Pain	❑	❑	Liver Problems	❑	❑	Gas After Meals
❑	❑	Shoulder Pain	❑	❑	Osteoporosis	❑	❑	Constipation
❑	❑	Artificial Joints	❑	❑	Osteopenia	❑	❑	Weight Gain
❑	❑	Psychiatric problems	❑	❑	Bloating After Meals	❑	❑	Weight Loss
❑	❑	Fatigue	❑	❑	Diarrhea	❑	❑	Depression
❑	❑	Visual Disturbances	❑	❑	Gall Bladder Disorder	❑	❑	Chest Pains
❑	❑	Painful Urination	❑	❑	Loss /Bladder Control	❑	❑	Congenital Heart Defect

Who have you seen for your symptoms?

❑ No one ❑ Chiropractor ❑ Acupuncturist ❑ MD ❑ PT
❑ Naprapath ❑ Massage therapist ❑ Other _____

What describes the nature of your symptoms? ❑ Sharp ❑ Numb ❑ Shooting ❑ Tingling
❑ Dull Ache ❑ Tight / Tense ❑ Burning ❑ Throbbing

Indicate if an immediate family member has had any of the following:

❑Heart Problems ❑Diabetes ❑Cancer ❑Rheumatoid Arthritis

Please list any other serious medical conditions you may have ever had:_____

List previous surgeries with dates: _____

For Women: Are You:

Taking birth control pills?	❑Yes	❑No
Pregnant?	❑Yes	❑No
Nursing?	❑Yes	❑No
Menstrual Cramping?	❑Yes	❑No
Cramps in Calves at Night?	❑Yes	❑No
Back Pain during Menses?	❑Yes	❑No

Date of last PAP Smear :_____

Date of last Mammography Test: _____

For Men: Do you have:

History of Prostate Problems?	❑Yes	❑No
Low Back Pain?	❑Yes	❑No
Difficulty Urinating?	❑Yes	❑No
Painful Urination?	❑Yes	❑No
Blood in Urine?	❑Yes	❑No

How many times do you awake to urinate?____ times

❑Our policy requires payment in full for all services rendered at the time of visit. unless other arrangements have been made. If account is not paid within 90 days from the date of service & no financial arrangements have been made,you will be responsible for any expenses incurred in collecting your account.

❑ I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

❑ If this is an accident, personal injury, workmen's comp or attorney involved case I hereby give a lien on any settlement, claim, judgement, or verdict as a result of said accident/illness and authorize and direct my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing doctor for all services rendered me.

❑ As required by HIPPA regulations, I acknowledge that I have read Americare Notice of Privacy Practices.

Signature _____ Date: _____