ADVANCED
physical medicine
& therapy, ltd.

Name :

Street Address:

City: State: Zip:

____Male ___Female Marital Status:____Single _____Married
Date of Birth: _____Divorced _____Widowed

Home Phone: Cell Phone:

Work Phone: Cell Phone Carrier:

Please prioritize phone numbers when contacting you. (number 1,2,3) ___home, ____work, ___cell

Our office sends reminders by text and email.
Would you like to receive reminders by: ____ email ___text ___both ___please don't send me reminders.

Who is responsible for payment of this account?

If different from self, please provide contact information. Phone Number:

Street Address:

City: State: Zip:

Policy Holder Name:

If different from self, please provide contact information. Phone Number:

Street Address:

City: State: Zip:

Primary Care Physician: City:

Phone:

May we update your physician of your treatment in our office? _____Yes _____No

Whom may we thank for referring you to our office?_____

Emergency Contact: Relationship: Phone:

Signature: Date:

Have you seen a chiropractor before? __Yes ___ No

Date of Last:

Primary Care Physician Exam: _____	Spinal Exam: _____
Dental X-Ray	Chest X-Ray
Urine Test	Blood Test
MRI/CT Bone Scan	

List all prescription, non-prescription medications and other supplements you take:

MEDICATION	STRENGTH/ FREQUENCY	MEDICATION	STRENGTH/ FREQUENCY	VITAMINS/HERBS/MINERALS	STRENGTH/ FREQUENCY

ALLERGIES: _____

Describe the reason(s) for your doctor visit today (include area(s) of pain):

_____

_____

Complaint 1 _____
Pain Level: 0-10 (0= No Pain; 10= Unbearable/Worst Pain Ever): Current _____ Average _____ Worst _____ Best _____
Complaint 2 _____
Pain Level: 0-10 (0= No Pain; 10= Unbearable/Worst Pain Ever): Current _____ Average _____ Worst _____ Best _____
Complaint 3: _____
Pain Level: 0-10 (0= No Pain; 10= Unbearable/Worst Pain Ever): Current _____ Average _____ Worst _____ Best _____

When did your symptoms start? _____ How did your symptoms begin? _____

Have you experienced these symptoms in the past?_____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

Does your pain interfere with the following activities?

☐Work ☐Normal Daily Activities ☐Sleep ☐Exercise ☐Walking ☐Driving ☐Other:_____

What activities make it feel worse: _____

What activities make it feel better:_____

Please list your goals or expectations you have: _____

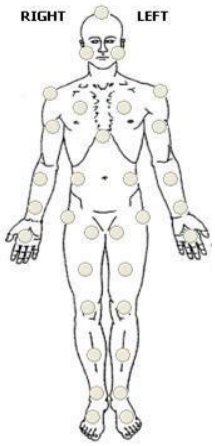
_____

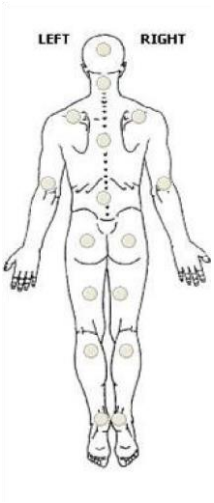
Additional comments you would like the doctor to know: _____

_____

Please grade pain 0-10 (10 is the highest)

0	1	2	3	4	5	6	7	8	9	10





This complaint came on	O Gradually	O Immediately	
It is getting:	O Improving	O Staying the Same	O Getting Worse
The intensity of this complaint is:	O Minimal O Slight	O Moderate	O Severe
The frequency of this complaint is:	O Occasional	O Frequent	O Constant
The pain is:	O Dull	O Sharp	O Aching
	O Shooting	O Spasm	O Throbbing
	O Burning	O Tingling	
The pain is located on the:	O Left side	O Right side	O Both sides

Actions effecting this complaint

Morning	O Brings On	O Aggravates	O Relieves
Afternoon	O Brings On	O Aggravates	O Relieves
Bending forward	O Brings On	O Aggravates	O Relieves
Bending back	O Brings On	O Aggravates	O Relieves
Bending left	O Brings On	O Aggravates	O Relieves
Bending right	O Brings On	O Aggravates	O Relieves
Twisting left	O Brings On	O Aggravates	O Relieves
Twisting Right	O Brings On	O Aggravates	O Relieves
Coughing	O Brings On	O Aggravates	O Relieves
Sneezing	O Brings On	O Aggravates	O Relieves
Straining	O Brings On	O Aggravates	O Relieves
Standing	O Brings On	O Aggravates	O Relieves
Lifting	O Brings On	O Aggravates	O Relieves
Sitting	O Brings On	O Aggravates	O Relieves
Heat	O Brings On	O Aggravates	O Relieves
Cold	O Brings On	O Aggravates	O Relieves
Resting	O Brings On	O Aggravates	O Relieves
Lying Down	O Brings On	O Aggravates	O Relieves
Medication	O Brings On	O Aggravates	O Relieves

Office Use ONLY

BP (mmHg)_____/_____ Height(in)_____ Weight(lbs)_____ Pulse _____ O2 _____

Examiner _____ CA _____ Initials_____