



Advanced Health Center

NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your Driver's License and Insurance card (if applicable).

PLEASE PRINT CLEARLY.

Full Name: _____ Gender: M F Age: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security#: _____ - _____ - _____ E-mail _____ Home Phone: (____) _____
Marital Status: S M D W # of Children: _____ Work Status: Full time Part-time Retired Cell: (____) _____
Females: Last Menstrual Period: _____ Pregnant? Y N Nursing? Y N Fax: (____) _____
Employer: _____ Occupation: _____ Work Phone: (____) _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Name of Spouse, Parent or Guardian: _____ Age: _____ Birth Date: _____ SS#: _____ - _____ - _____
Spouse's Employer: _____ Spouse's Occupation: _____ Work Phone: (____) _____
In case of an Emergency Contact: _____ Relationship: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
Do you have Medicare Insurance? Y N Medicare card copied by Office Staff
 Drivers license copied by Office Staff

Who may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Dr. Lindon W. Keeler, DC to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Advanced Health Center to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: _____ Date: _____

Spouse's or Guardian's Signature: _____ Date: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

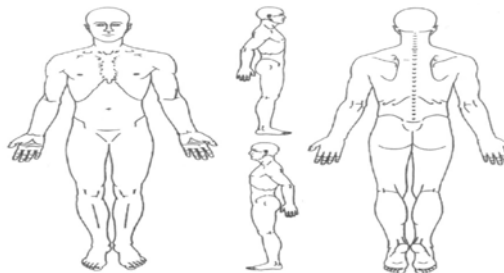
- 1) _____
- 2) _____
- 3) _____
- 4) _____

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.
 I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.
 I am looking to take care of my problem and then go on to “achieve optimal health and wellness.”

Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:

- | | |
|--------------------|-----------------|
| SS = spasms | ST = stiffness |
| DP = dull pain | SP = sharp pain |
| SH = shooting pain | TI = tingling |
| NU = numbness | O = Other |



COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: Y N
 Whom? MD DO DC DDS Other: _____ Name of primary doctor? _____
 Treatment(s) Tried: Medication Surgery Lifestyle change Chiropractic other _____
 Have you had any intolerance or reactions to treatments? Y N Describe: _____
 When did the problem start?: _____ How did it originally occur? _____
 Has it become worse recently? Y N Same Better Gradually worse How frequent is the condition? Constant Daily Intermittent
 How long does it last? All day Few hours Minutes Is this condition interfering with your? Work Sleep Daily routine Recreation
 Does anything relieve the symptom(s)? Y N Medication(prescription or OTC) Rest Exercise/Stretch Other: _____
 If no, what have you tried? Medication (prescription or OTC) Rest Exercise/Stretch Surgery
 Is there anything that you can do to relieve the symptom? Y N Medication(prescription or OTC) Rest Exercise/Stretch Other: _____
 If no, what have you tried to do that has not helped? Medication (prescription or OTC) Rest Exercise/Stretch Surgery Chiropractic
Other: _____
 How long has it been since you really felt good? Days Weeks Months Years >10 years
 Describe the pain/problem: Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____
 What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____
 What do you believe is cause of the problem? _____
 Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? _____

Please check all of the symptoms that apply. (P=Past / C= Current)

- | | | | | |
|--|--|--|---|--|
| P / C
<input type="checkbox"/> Headache
<input type="checkbox"/> Walking Problems
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Earache
<input type="checkbox"/> Sweating
<input type="checkbox"/> Constipation
<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Impatience
<input type="checkbox"/> Tingling in Hands
<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Joint Stiffness
<input type="checkbox"/> Other: _____ | P / C
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Weak Muscles
<input type="checkbox"/> Fullness of Bladder
<input type="checkbox"/> Confusion
<input type="checkbox"/> Fainting
<input type="checkbox"/> Decreased Sex Drive
<input type="checkbox"/> Unpleasant Taste
<input type="checkbox"/> Feel Loss of Control
<input type="checkbox"/> Swallowing Pain
<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Slow Heart Rate | P / C
<input type="checkbox"/> Tingling in Feet
<input type="checkbox"/> Abdominal Pains
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Shakiness
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Teeth Grinding
<input type="checkbox"/> Irritability
<input type="checkbox"/> Elbow / Hand Pain
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Hip Pain
<input type="checkbox"/> Persistent Coughing
<input type="checkbox"/> Swollen Ankles | P / C
<input type="checkbox"/> Facial Pain
<input type="checkbox"/> Sore Muscles
<input type="checkbox"/> Poor Appetite
<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Clammy Hands
<input type="checkbox"/> Unsteady Voice
<input type="checkbox"/> Swollen Joints
<input type="checkbox"/> Rapid Heart Rate | P / C
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Urination Difficulty
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Convulsions
<input type="checkbox"/> Menstrual Irregularities
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Lump in Throat
<input type="checkbox"/> Knee Pain
<input type="checkbox"/> Chest Pressure
<input type="checkbox"/> Ankle / Foot Pain |
|--|--|--|---|--|

Patients Name: _____ Date: _____

ALLERGIES/Sensitivities: Please check and list all allergies.

- Food: Dairy Wheat Corn Soy Seafood Gluten Peanuts Fruits Other: _____
- Medications: Penicillin Sulfa Drugs Iodine Insulin Antibiotics Other: _____
- Seasonal/Other: Pollen Dust Hay Mold Chemical(s) Smoke Animals Insects Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	<u>Medication Name</u>	<u>Date Started</u>
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-Diabetics		
<input type="checkbox"/> Anti-Inflammatory		
<input type="checkbox"/> Blood Pressure Lowering Meds.		
<input type="checkbox"/> Cholesterol Lowering Meds.		
<input type="checkbox"/> Hormone Replacements (HRT)		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> OTC (over the counter) Other		

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? Y N If yes, who recommended them? _____

SCARS / SURGICAL PROCEDURES: Have you had any surgical procedures? YES NO Any Scars? YES NO

SPINE: Cervical Thoracic Lumbar EXTREMITIES: Shoulder/Elbow/Hand/Wrist R L Hip/Knee/Ankle/Foot R L

ABDOMINAL/CHEST: Appendix Colon Gall Bladder Heart Lungs Breast Other: _____

HABITS:

	Heavy	Moderate	Light	None	5-7x/wk	3-5x/wk	1-3x/wk	None	Type
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Aerobic <input type="checkbox"/> Weights
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Soda / Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5+	4	3	2	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64+ oz	32-64 oz	16-32 oz	<8 oz	
					Water / day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

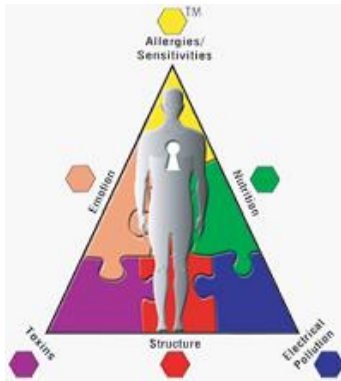
WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking / Moving Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(F = Family, P = Personal History)

- | | | | |
|--------------------------|-------------------|---------------------|------------------|
| ___ Alcoholism | ___ Eczema | ___ Miscarriage(s) | ___ Tumor(s) |
| ___ Anemia | ___ Emphysema | ___ Mumps | ___ Ulcer(s) |
| ___ Cancer | ___ Epilepsy | ___ Pleurisy | ___ Other: _____ |
| ___ Cold sores | ___ Goiter | ___ Pneumonia | _____ |
| ___ Deep vein thrombosis | ___ Gout | ___ Polio | _____ |
| ___ Detached retina | ___ Heart disease | ___ Rheumatic fever | |
| ___ Diabetes | ___ HIV / AIDS | ___ Stroke | |

Patient's Printed Name Patient's Signature Date

Reviewed By: _____ Date: _____



Patient Billing Information

I understand that all payments are due to **Dr. Lindon W. Keeler, D.C.** at the time services are rendered, except when prior arrangements are made. All bills are due and payable in full.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. A complete list is available at the front desk.

Insurance Billing: Regence, Medicare Labor & Industries, PI insurances accepted (no 3rd party)

Note: Manipulation is the only covered Chiropractic service by Medicare.

A charge of \$45.00 will be assessed for a missed appointment. We require a 24-hour notice for cancellations.

If you or your insurance company request copies of your medical records, a \$23.00 copy charge as well as \$1.02 per page (pages1-30), .78cents (pages31 and over) will be billed to you. You may try to recover this charge from your insurance company.

Any financial arrangements are to be determined prior to services rendered.

I agree to the terms above, and acknowledge that in the event that there is an outstanding balance, which fails to be cured within sixty (60) days, my account with **Dr. Lindon W Keeler, DC** will be turned over to collection. I understand that should this happen, I will remain responsible for any and all additional collection fees and/or attorney and court costs.

Signature

Date