Patient Name: ______________________________ **Date:** ______________

I prefer to be called______________ Social Security #__________________Sex M F

Address____________________City__________ State ______ Zip Code ______

Home Phone ______________Work Phone__________Cell Phone ____________

Email Address: ____________ Marital Status M S D W Date of Birth_________Age___

Occupation______________Employer________________Days off: S M T W TH F S

1. **Reason(s) For This Visit** (You will continue on Page #4 to fill in more questions about each symptom.)
   What is your Worst Complaint or Primary Reason?__________________________
   What is your Second Worst Complaint? __________________________
   What is your Third Worst Complaint? __________________________
   What is your Fourth Worst Complaint? __________________________
   What is your Fifth Worst Complaint? __________________________
   What is your Sixth Worst Complaint? __________________________

2. **Review of Symptoms** (Please check all symptoms you have noticed now (present) or in the past.)

Past/Present	Past/Present	Past/Present	Past/Present	Past/Present
□/□Head feels heavy	□/□ Hands tremble	□/□ High blood pressure	□/□ Vision blurred	□/□Prostate problem
□/□ Neck pain	□/□ Loss of balance	□/□ Heart skips beats	□/□ Dry skin	□/□ Cancer
□/□ Jaw pain	□/□ Loss of memory	□/□ Rapid heart beats	□/□ Excess sweating	□/□ Impotent
□/□ Mid back pain	□/□ Muscle twitching	□/□ Varicose veins	□/□ Nail Fungus	□/□ Fatigue
□/□ Back pain	□/□ Numb arms	□/□ Asthma	□/□ Stomach upset	□/□ Appetite change
□/□ Heel spurs	□/□ Numb fingers	□/□ Difficulty breathing	□/□ Constipation	□/□ Diabetes
□/□ Joint stiffness	□/□ Numb legs	□/□ Loss of taste	□/□ Diarrhea	□/□ Weight change
□/□ Joint pain	□/□ Numb toes	□/□ Loss of smell	□/□ Heartburn	□/□ Night sweats
□/□ Muscle cramps	□/□ Stroke	□/□ Trouble swallowing	□/□ Nausea	□/□ Depression
□/□ Muscle tension	□/□ Chest Pain	□/□ Ear noises/ringing	□/□ Bed wetting	□/□ Nervousness
□/□ Headaches	□/□ Hands/Feet blue	□/□ Frequent colds	□/□ Bladder problems	□/□ Irritable
□/□ Dizziness	□/□ Hands/Feet cold	□/□ Motion sickness	□/□ Difficult urinating	Other__________
□/□ Double vision	□/□ Lightheadedness	□/□ Light bothers eyes	□/□ Frequent urination	Other__________

3. **Past Health History:**
   A. **Previous illnesses you've had in your life (with approximate dates):**
   ____
   B. **Previous Injury or Trauma (with approximate dates):**
   ____
   C. **Have you ever broken any bones? Which? (with approximate dates):**
   ____
   D. **Allergies:**
   ____
   E. **Medications:**
   Medication/Vitamins Reason for taking
   ____
   ____
   ____
   ____
   ____
   ____

Who is your family doctor?______________May we send a copy of our findings to him/her? (Yes/ No)
Please list any medical problems for which you regularly see a doctor such as high blood pressure, diabetes, etc.
____

22 Sardis Road Asheville, NC 28806 **(828) 667-8000**

Patient Name: ____ **Date:** ______________________

F. Surgeries:

Date Type of Surgery

____ ____

____

____ ____

____

____

G. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

____ ____

____

____ ____

____

*Women only: Are you on Birth Control Pills?(Yes/No) Are you pregnant?(Yes/No) Date of last period*___________

4. Family Health History:

Associated health problems of relatives:

____

____

____

Deaths in immediate family:

Cause of parents or siblings death Age at death

____

____

____

5. Social and Occupational History:

A. Job description:

____

B. Work schedule:

____

C. Recreational activities (hobbies):

____

D. Lifestyle (level of exercise, diet, alcohol, tobacco and drug use):

Do you exercise regularly? Y/N Type_________________Frequency__________Hours sleep/night______

Overall, how healthy is your diet?____Excellent____Good____Fair____Poor Water intake/day_______

Tobacco use? Y/N Frequency__________________Alcohol use? Y/N Frequency______________________

Caffeine use? Y/N Frequency__________________History of recreational drug use? Y/N Type_________

Previous chiropractic care: Physician's Name(s)____

Date of first visit_____________________Were X-rays taken? (Yes/No) Date of last visit____________________

Is there anything else we should know about your health?____

____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with North Carolina's state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Dr. Gary Walicki / Advanced Chiropractic Center** for services performed.

Patient or Parent/Guardian Signature____Date______________

Patient Name: ____ **Date:** _______________________

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_________________________________ _________________________
Signature of Patient of Representative Date

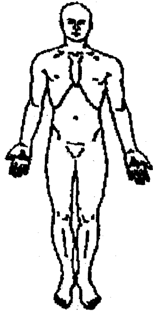
____
Printed Name

22 Sardis Road Asheville, NC 28806 **(828) 667-8000**

Patient Name: ____ **Date:** ______________________

NEW PATIENT HISTORY FORM

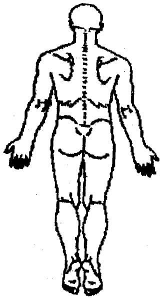
Symptom #1 (What is your Worst Complaint?)____



- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin/ what caused it? ______________________________

    ____
  - Have you had this symptom before this episode? Yes/No

    --If yes, when/how long ago?____



- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _________________________

    ____

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ___________________________________
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?____
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?____

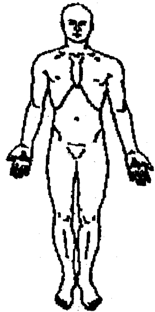
  ____
- ____

22 Sardis Road Asheville, NC 28806 **(828) 667-8000**

Patient Name: ______________________________ **Date:** ______________

NEW PATIENT HISTORY FORM

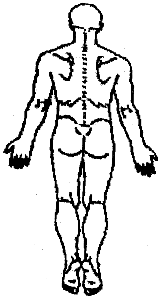
Symptom #2 (What is your Second Worst Complaint?)______________________________



- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin/ what caused it? ______________________________

    ____
  - Have you had this symptom before this episode? Yes/No

    --If yes, when/how long ago?______________________________



- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________

    ____

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ______________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________

- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?______________________________
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?______________________________

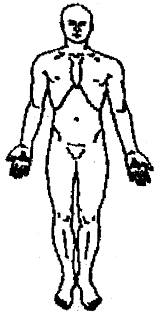
  ____
- ______________________________

22 Sardis Road Asheville, NC 28806 **(828) 667-8000**

Patient Name: ______________________________ **Date:** ______________

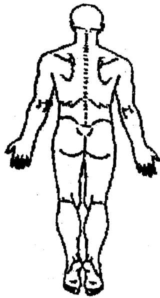
NEW PATIENT HISTORY FORM

Symptom #3 (What is your Third Worst Complaint?)______________________________



- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin/ what caused it? ______________________________
    ____
  - Have you had this symptom before this episode? Yes/No

    --If yes, when/how long ago?______________________________



- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________
    ____

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ______________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________

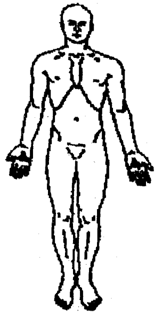
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?______________________________
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?______________________________
  ____
- ______________________________

22 Sardis Road Asheville, NC 28806 **(828) 667-8000**

Patient Name: ____ **Date:** ______________________

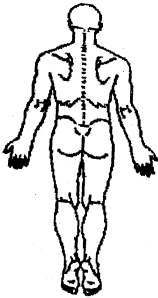
NEW PATIENT HISTORY FORM

Symptom #4 (What is your Fourth Worst Complaint?)____



- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin/ what caused it? ______________________________
    ____
  - Have you had this symptom before this episode? Yes/No

    --If yes, when/how long ago?____



- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): __________________________
    ____

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? __________________________________
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

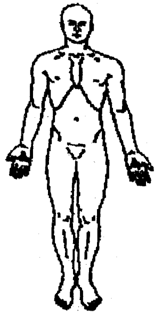
- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?____
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?____
  ____
- ____

22 Sardis Road Asheville, NC 28806 **(828) 667-8000**

Patient Name: ____ **Date:** _____________________

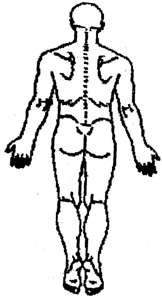
NEW PATIENT HISTORY FORM

Symptom #5 (What is your Fifth Worst Complaint?)____



- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin/ what caused it? _____________________________
    ____
    - Have you had this symptom before this episode? Yes/No

      --If yes, when/how long ago?____



- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _________________________
    ____

- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? ___________________________________
- Is the symptom worse at certain times of the day or night? (Circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

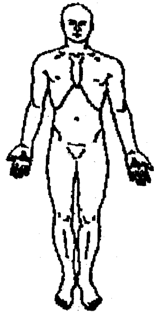
- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?____
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?____
____
- ____

22 Sardis Road Asheville, NC 28806 **(828) 667-8000**

Patient Name: ____ **Date:** ______________________

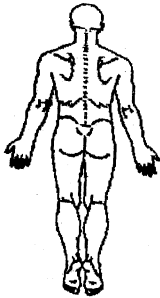
NEW PATIENT HISTORY FORM

Symptom #6 (What is your Sixth Worst Complaint?)____



- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin/ what caused it? ______________________________
    ____
  - Have you had this symptom before this episode? Yes/No

    --If yes, when/how long ago?_______________________________________



- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _________________________
    ____

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? __________________________________
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?____
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?____
  ____
- ____

22 Sardis Road Asheville, NC 28806 **(828) 667-8000**