

ADVANTAGE MEDICAL GROUP

1104 E. 23rd Street
Lawrence, Ks 66046
Phone: (785) 749-0130 Fax: (785) 749-0132

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____
Birth Date: _____ Sex: M ___ F ___ Height: _____ Weight: _____
SS# _____ Email: _____

Emergency Contact with Different Address and Phone Number than yourself:

Name: _____ Phone: _____
Address: _____ City, State, Zip: _____
Who referred you to the office or how did you hear about us? _____

Who is responsible for your bill? Health Insurance ___ Self Pay ___ Work Comp ___ Auto Insurance ___

Primary Insurance:

Insured's Full Name: _____ Relationship to You: _____
Insured's DOB: _____ Insured's Employer: _____

Secondary Insurance:

Insured's Full Name: _____ Relationship to You: _____
Insured's DOB: _____ Insured's Employer: _____

Please list all other physicians

Last Visit There

Treatment Received

Primary Care Dr: _____
Chiropractor: _____
Other Physicians: _____

Date of Last Lab Work: _____ Where did you have it done: _____

Are present problems due to an accident/injury: () Yes () No

() Auto () Work () Home () Other: _____

Accidents or falls (please describe): _____

Fractures or Dislocations: _____

List All Medications Or Over the Counter Drugs: _____

Vitamins: _____

Reason for Treatment Today Date Started Rate Pain (1 is low-10 is high)

#1 _____
#2 _____
#3 _____
#4 _____

Pain Interferes With: ___ Sitting ___ Walking ___ Work ___ Standing ___ Sleep ___ Daily Activities

Patient Signature: _____ **Date:** _____ **Witness:** _____

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Patient Name: _____ DOB: _____

Personal Health History

Past/Current Medical History (mark yes or no and circle area if necessary)

Diabetes	Y___N___	High Blood Pressure	Y___N___	Anemia	Y___N___
Heart Disease	Y___N___	Arthritis	Y___N___	Gastrointestinal	Y___N___
Cholesterol	Y___N___	Thyroid Disease	Y___N___	Cancer (Type: _____)	Y___N___
Lung Disease	Y___N___	Kidney Disease	Y___N___	Other _____	

If you said yes to any of the above please explain for how long?

Have you been hospitalized for a serious illness?

Heart Attack	Y___N___	Mental Illness	Y___N___	Meningitis/encephalitis	Y___N___
Stroke	Y___N___	Seizures	Y___N___	Other _____	

If you said yes, please explain when and where: _____

Any Operations Y___N___ If yes, please explain: _____

Any allergies to medications: _____ Immunizations up to date Y___N___

General Health:

Y___N___ Weight gain/loss	Y___N___ Energy level	Y___N___ Skin, nails or hair
Y___N___ Anxiety/depression	Y___N___ Sleeping pattern	Y___N___ Swollen nodes/bumps

Head:

Y___N___ Headaches	Y___N___ Dizziness	Y___N___ Ears/balance/hearing
Y___N___ Nose/sinuses/allergies	Y___N___ TMJ(jaw joint pain)	Y___N___ Eyes/Vision

Musculoskeletal: (pain or numbness)

Y___N___ Neck	Y___N___ Mid/Upper Back	Y___N___ Low back
Y___N___ Arms/Shoulders/Hands	Y___N___ Legs/Knees/Feet (Sciatica)	

Chest:

Y___N___ Heart (chest pains/palpitations) Y___N___ Lungs (asthma, emphysema, shortness of breath)

Stomach:

Y___N___ Heartburn, ulcers	Y___N___ Sexual function	Y___N___ Bowels
Y___N___ Liver/pancreas/gallbladder	Y___N___ Bladder	

Women: Date of last menstrual period: _____ Periods regular Y___N___

Pregnant Y___N___ If yes, how far along are you: _____

Patient Signature: _____ **Date:** _____ **Witness:** _____

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Patient Name: _____

DOB: _____

Family History

Member	Age	If deceased, cause of death:
Father		
Mother		
Brother(s)		
Sister(s)		
Children		

Do you have any **family history** of the following:

Stroke	Y__N__	Heart Disease	Y__N__	Depression	Y__N__
Heart attack	Y__N__	Alcoholism	Y__N__	Suicide	Y__N__
Cancer	Y__N__	Diabetes	Y__N__	High Blood Pressure	Y__N__
Thyroid Problem	Y__N__	Migraine	Y__N__	Other	_____

If you answered "yes" to any of the above questions please indicated which family member?

Social History

Marital Status S__M__D__W__ Spouses Name _____ Phone # _____

Race/Ethnicity: _____ # of Children: _____ Your Highest level of education: _____

Occupation: _____ Employer: _____

Do/did you smoke/chew tobacco? _____ If yes, _____ packs per day for (how many) _____ years.

Do you drink alcohol? _____ If yes, how much? _____

Do/did you ever use recreation drugs? If yes, what substance? _____

Do you consume caffeine (coffee/tea/cola)? If yes, how many cups or glasses a day? _____

How many cups of water do you drink per day? _____

Are you under much stress? _____ From your job? _____ From your personal life? _____

Do you exercise? Y__N__ How many times per week? _____ Kinds of exercise _____

Average hours of sleep per night _____ Hobbies _____

Patient Signature: _____ Date: _____ Witness: _____