Advantage Chiropractic PLLC
430 S. Broad St. #130
Mankato, MN 56001

ABOUT THE PATIENT

Name _____ **Today's Date**_____ **Birthdate** _____ **Age**_____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____ **Gender** ❑ **M** ❑ **F**

Significant Other's Name _____ **Kid's Names and Ages** _____

Your Employer _____ **Type of Work** _____

E-Mail Address _____ **Have you been to a chiropractor before?** □ **No** □ **Yes**

Emergency Contact _____ **Ph #** _____

Name of Medical Doctor(s)_____

- **I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.**
- **I authorize Advantage Chiropractic to release and / or request records to or from other providers as may be necessary.**
- **I understand I am responsible for all bills incurred in this office.**
- **I authorize assignment of my insurance benefits (if applicable) directly to the provider.**
- **Person responsible for this account if other than the patient?**_____
- **I understand that after any initial promotional services all care is rendered at usual and customary fees.**
- **For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.**

_____ _____

Patient / Parent Signature **(This represents a long term authorization for all occasions of service)** **Date**

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. **Does your condition affect:** ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. **What makes it better?** _____

7. **What makes it worse?** _____

8. **What Doctor's have you seen for this?** _____

_____

9. **Type of treatment:** _____

10. **Results:** _____

NOTES: _____

_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark All areas of concern.