Advantage Chiropractic Center. 12401 Middlebrook Road, Germantown Md. 301-353-9676.

Patient Demographics

Today's Date _____ **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name _____ **Preferred Name** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City _____ **State** _____ **Zip Code** _____

Date of Birth _____ **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** (Optional, some ins. require) _____

Primary Phone # _____ **Work Phone #** _____

Mobile Phone # _____

Would you like to receive text reminders of your appointments? *(check one)* ❑ Yes ❑ No
We cannot receive reschedules or cancellations via text. Traditional texting rates apply, per your mobile phone carrier plan

Emergency Contact _____ **Phone #** _____

How did you hear about us? _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation _____ **Name Of Employer** _____

Email _____
By providing my email address, I authorize my doctor to contact me via the email address(es) to provide information for clinic's Patient Portal, clinic updates and the Quarterly Newsletter.

Contact Method *(check one)*

❑ Primary Phone ❑ Work Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Email

What time of day would you most likely be available? _____ A.M./P.M.

Insurance Source ***(check one)***

❑ Self ❑ Employer ❑ Medicare ❑ Medical Assistance ❑ Worker's Comp. ❑ Auto ❑ None/Cash

Name of Insurance Company _____

Group Number _____ **Policy Number** _____

Name of Policy Holder _____

Date of Birth of Policy Holder _____

Claim Number _____

Advantage Chiropractic Center. 12401 Middlebrook Road, Germantown Md. 301-353-9676.

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Primary Care Physician _____ **Phone** _____

Is it ok if we send a report to your physician? ☐ **yes** ☐ **no**

Advantage Chiropractic Center. 12401 Middlebrook Road, Germantown Md. 301-353-9676.

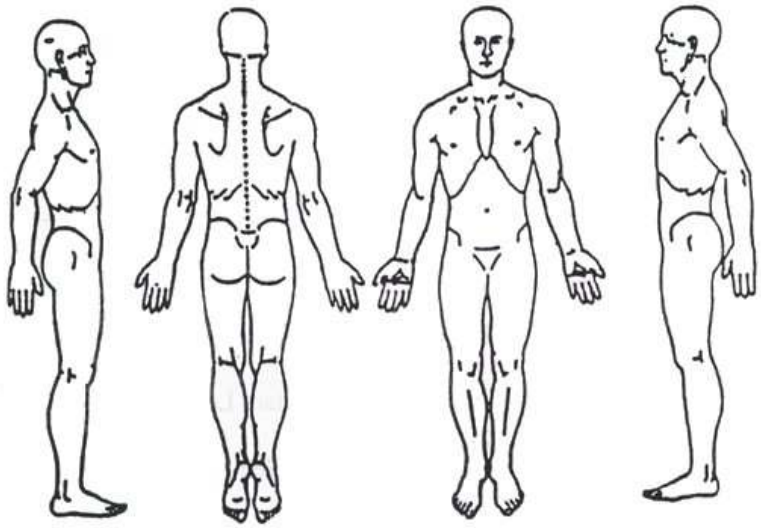
Patient Health Questionnaire

Name: _____Today's Date: _____

Signature: _____

Briefly list the reason for today's office visit _____

****Please indicate below where you have pain or other symptoms****



When did your symptoms start? (mm/dd/yy) _____

How did your symptoms begin? _____

The condition I present with today happened: ***(check one)*** ❑ At work ❑ Auto Collision ❑ Other

How often do you experience your symptoms?

❑ 76-100% of the day ❑ 51-75% of the day ❑ 26-50% of the day ❑ 0-25% of the day

What best describes the nature of your symptoms?

❑ Sharp ❑ Dull ache ❑ Numb ❑ Tingling ❑ Burning ❑ Shooting ❑ Radiating ❑ Deep ❑ Stiff

How are your symptoms changing? ❑ Getting Better ❑ Not Changing ❑ Getting Worse

I would rate the average intensity of my symptoms:

No pain at all ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 **I need to go to the E.R.**

How much have these symptoms interfered with your normal workweek? (ie. work, housework inside and out)

❑ All the time ❑ Most of the time ❑ Some of the Time ❑ A little of the time ❑ None of the time

How much time has your condition interfered with your social activities?

❑ All the time ❑ Most of the time ❑ Some of the Time ❑ A little of the time ❑ No

Have you seen anyone else for these symptoms? ❑ Yes ❑ No

If 'yes', who and what your treatment? _____

_____

Have you had an X-ray, C.T. scan or M.R.I. of your spine in the past 28 days? ❑ Yes ❑ No

If Yes, Where? _____

Have you had similar symptoms in the past? ❑ Yes ❑ No

Current medications and nutritional supplements, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Height:_____inches **Weight:**_____pounds **BP:**_____ / _____ **Temp:**_____***Degrees F***