

Advanced Health Chiropractic
George Khoury, D.C. and Matthew Jagels, D.C.

Name _____ Address _____

City _____ State _____ Zip _____ Home phn _____ Cell phn _____

E-mail _____ Work E-mail _____

SSN _____ Date of Birth _____ Age _____ Height _____ Weight _____

Male ___ Female ___ Single ___ Married ___ Divorced ___ # of children ___ Name of spouse or parent _____

Employer _____ Address _____

City _____ State _____ Zip _____ Wk phn _____ Occupation _____

What is your family physicians name? _____ What city are they located in? _____

Have you ever had Chiropractic care before? ___ If yes, doctor name: _____ Date of last visit _____

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

Currently or in the past have you ever experienced any of these complaints while working? _____ If yes, please describe what activities at work may be causing you to experience these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____ If yes, please explain: _____

Have you at any time in the past ever suffered a work injury? ___ If yes, what is the date of injury? _____

Do you have an attorney representing you for this work injury? ___ Yes ___ No If yes, who is your attorney? _____

Have you been involved in an auto accident in the last 12 months? ___ Yes ___ No If yes, what is the date of the auto accident? _____

Do you have an attorney representing you for this auto accident? ___ Yes ___ No If yes, who is your attorney? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

If due to an auto accident, what is the name of your auto insurance company? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any current or past injuries & illnesses not listed above: _____

Please check all medications (over the counter and/or prescribed) you are currently taking: _____ Aspirin/Tylenol _____ Pain killers

_____ Muscle Relaxers _____ Insulin _____ Birth Control Pills _____ Sleeping pills _____ Anti-Depressants _____ Others

Health Insurance Co. Name _____ Policyholder _____

Name of Spouse's health insurance (If applicable) _____ Policyholder _____

