ADVANCED HEALTH & REHAB
3120 S Main St, Ste 5, Joplin, MO 64804

417-782-2504
Fax: 417-553-7760

NEW PATIENT INFORMATION

Please Print all Answers

Name ______ Age ______ Sex ______ Date ______

Address ______ City ______ Zip ______

Phone ______ Work ______ Cell ______

Social Security # ______ Birthdate ______

E-mail ______ Family Doctor ______

□ Married □ Single □ Sep □ Divorced □ Widowed Spouse's Name ______

Employer ______ Spouse's Employer ______

Employer Address ______ Spouse's Birthdate ______

Employer Phone ______ Spouse's Social Security ______

Parent's Employer If Patient Is Minor / Child ______

Parents Social Security # If Patient Is Child ______

Emergency: Who Do We Call? ______ Phone ______ Relationship ______

Name of Relative or Friend Not Living with You ______ Phone ______

HEALTH INSURANCE INFORMATION

Name of Insurance Company ______ Group Number ______

Name of Insured (Policy Holder) ______ Policy Number ______

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company ______

Agent Name ______ Adjuster's Name ______

Accident Claim Number ______ Phone Number ______

Name of LIABLE Insurance Company ______ Adjuster's Name ______

Claim Number ______ Phone Number ______

Attorney Name ______ Phone Number ______

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party ______

Contact Person ______ Phone Number ______

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering family practice & pain management medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & psychological counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged $15.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day or through our 24 hour - 7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

– please proceed to page 2 –

ADVANCED HEALTH & REHAB
1731 E. 20TH, STE C, JOPLIN, MISSOURI 64804

417-782-2504
FAX: 417-782-4726

PATIENT & FAMILY HISTORY

What is your occupation? ______________________
Do you use tobacco? □ No □ Yes Explain Usage: ______________________
Do you consume alcohol? □ No □ Yes Explain Frequency: ______________________
Do you have a history of substance abuse? □ No □ Yes Explain: ______________________
List all past medical conditions ______________________
List your family medical history ______________________
List all past surgeries ______________________
List all drug allergies ______________________

SYMPTOM SURVEY

What is your chief problem or symptoms? ______________________
What caused the problem or symptoms to occur? ______________________
When did the problem or symptoms begin? ______________________
Have you seen another doctor for this problem? □ No, If yes, who ______________________
Have you had this problem or symptoms in the past? □ No, If yes, explain ______________________
Have you tried any other treatments for this? □ No, If yes, explain ______________________
Is the problem or symptoms getting worse? □ No, If yes, explain ______________________

□ THE BOX OF SYMPTOMS WHICH YOU **NOW** HAVE OR HAVE HAD IN THE **PAST**

{ Arthritis	{ Depression/Anxiety	{ Pregnancy	{ Seasonal Allergies	{ Headaches	{ Eye Pain–Strain
{ Dizziness	{ Balance Problems	{ Ringing in Ears	{ Blurred Vision	{ Jaw Pain	{ Bleeding Gums
{ Neck Pain	{ Neck Spasms	{ Neck Stiffness	{ Arthritis in Neck	{ Swallowing Difficulty	{ Thyroid Problems
{ Chest Pain	{ Chest Congestion	{ Shortness of Breath	{ Irregular Heart Beat	{ Heart Attack in Past	{ Asthma/Bronchitis
{ Mid Back Pain	{ Shoulder/Elbow Pain	{ Wrist or Hand Pain	{ Low Back Pain	{ Hip/Knee/Leg Pain	{ Foot or Ankle Pain
{ Abdominal Pain	{ Diabetes	{ Groin or Rectal Pain	{ Female Disorders	{ Urinary Problems	{ Skin Problems
{ Broken Bones	{ Digestive Problems	{ Nausea - Vomiting	{ Irregular Bowels	{ Other problem(s) not listed ________	

PAIN DRAWING

Draw location of your symptoms on body
Outline using the symbols for the type of sensation.

Pain ::::::::::::::
Numbness +++++++++++
Ache XXXXXXXXXX
Burning ////////////

Rate your Pain on a Scale of 1 (mild) to 10 (severe) _____

L R R L

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

{ Auto Accident Date __________ Time ____ [am] [pm] Location ______________________
Were You { Driver { Passenger Wearing a Seat Belt { YES { NO
{Unconscious { Treated in E.R. Transported by Ambulance { YES { NO
Vehicle Damage { Minimal - Moderate { Severe - Totaled Was the vehicle towed away { YES { NO
Police Report { None {Yes with Police Dept ______________________
Activities { No restrictions { Missed ____ days of work or school { I felt fine before the accident

{ Work Related or Other Injury Date __________ Time ____ [am] [pm] Type of Injury ______________________
{ No restrictions { Missed ____ days of work or school { I felt fine before the injury

- please proceed to page 3 -

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ACCIDENT & INJURY QUESTIONNAIRE

Name	Account	Date

☐ Automobile Accident

Date & Time of Accident ____________________

Describe how accident occurred and what happened to your body motion at the time of the accident.

____
____
____

How did you feel 24 hours before the accident?
☐ FINE — NO PAIN ☐ ____________________

Were you	☐ Driver	☐ Passenger
Others in car	☐ No	☐ Yes
Were they hurt	☐ No	☐ Yes
Wearing seat belt	☐ No	☐ Yes
Wearing eye glasses	☐ No	☐ Yes
Where were you hit	☐ Behind	☐ Front/Side
Damage to vehicle	☐ Minimal	☐ Moderate
Was car totaled	☐ No	☐ Yes
Did seat back break	☐ No	☐ Yes
Did glass break	☐ No	☐ Yes
Police report made	☐ No	☐ Yes
Did you go to E.R.	☐ No	☐ Yes
Had accident before	☐ No	☐ Yes
Missed any work	☐ No	☐ Yes

For insurance purposes please complete:

Your auto insurance co ____________________
Your auto agent ____________________
His/her phone number ____________________
This claim number ____________________
Adjusters name ____________________
Adjusters phone no. ____________________

Person who hit you ____________________
Their phone number ____________________
Their auto ins co. ____________________

Your attorney ____________________
Telephone number ____________________
Address (if known) ____________________

Other Insurance Information

____
____
____
____

☐ Work Related Injury

Date & Time of Accident ____________________

Describe how injury occurred in your own words. Be specific in details & accurate in pains & injuries.

____
____
____

How did you feel 24 hours before this injury?
☐ FINE — NO PAIN ☐ ____________________

Was injury report made	☐ No	☐ Yes
Report to supervisor	☐ No	☐ Yes
Missed any work	☐ No	☐ Yes
Had any work injury before	☐ No	☐ Yes
Seen company doctor yet	☐ No	☐ Yes
Were you authorized to see us	☐ No	☐ Yes

List your routine job duties in detail

____
____
____
____
____

For insurance purposes please complete:

Employer/Company ____________________
Your supervisor ____________________
Company phone no. ____________________
Company doctor name ____________________
Doctors phone number ____________________
Your med insurance ____________________
Your policy number ____________________

Your attorney ____________________
Telephone number ____________________
Address (if known) ____________________

Other Insurance Information

____
____
____
____