Advanced Medical Centers

15521 Midlothian Turnpike, Ste. 402
Midlothian, VA 23113
(804) 594-7272

Please Print

Patient Name: _____ Today's Date: _____

Personal History

PATIENT INFORMATION

Today's date:		**Primary Care Physician:**		
Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid / Sig Other	
Is this your legal name? ☐ **Yes** ☐ **No**	If not, what is your legal name?	(Former name):	Birth date: / /	Age: Sex: ☐ M ☐ F
Street address:	Social Security No. :	Home phone no.: ( ) Cell phone no.: ( )		
P.O. Box:	City:	State:	ZIP Code:	
Occupation:	Employer:	Employer phone no.: ( )		

Chose clinic because / Referred to clinic by (please check one box):

☐ Dr. Referral ☐ newspaper ☐ Hospital ☐ Family/Friend ☐ TV ☐ Dinner Event ☐ Mailer ☐ Other

Email:	Spouse's Name:

Please List any other family members/friends involved in your health decisions:

We often find our patients have the desire to help others suffering from nerve damage. List other family members/friends whose lives would improve with understanding of their condition:

Name: Phone Number:

Insurance Name:	☐ PPO ☐ HMO ☐ Other _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge.

Patient/Guardian signature: _____ *Date:* _____

Check all conditions that apply to you:

General	Neurological	Psychiatric	Respiratory
☐ Fatigue, tiredness ☐ Weakness ☐ Chills ☐ Fever ☐ Night sweat ☐ Appetite change ☐ Lived in foreign country ☐ Unexplained weight loss ☐ Unexplained weight gain ☐ Generalized pain ☐ Unable to tolerate heat ☐ Unable to tolerate cold ☐ Sedentary lifestyle ☐ Active lifestyle ☐ Other _____	☐ Fainting spells ☐ Seizures ☐ Paralysis ☐ Dizziness ☐ Tremor ☐ Chronic headaches ☐ Poor balance ☐ Fractured back or neck ☐ Numbness of face / arm / leg ☐ Peripheral neuropathy ☐ Stroke or Mini – stroke ☐ Other _____	☐ Depression ☐ Anxiety (abnormal) ☐ Panic attacks ☐ Alzheimer's ☐ Confusion (abnormal) ☐ Hospitalized for nervousness ☐ Substance abuse ☐ Anorexia ☐ Other _____	☐ Chronic obstructive disease ☐ Wheezing ☐ Chronic cough ☐ Coughing up blood ☐ Asthma ☐ Shortness of breath ☐ TB ☐ Lung Cancer ☐ Emphysema ☐ Chronic bronchitis ☐ Pneumonia ☐ Fluid in lungs ☐ Need to sleep sitting up ☐ Other _____
Cardiac	**Vascular**	**Gastrointestinal**	**Genitourinary**
☐ Angina (chest pain) ☐ Rapid heartbeat ☐ Past heart attacks ☐ Heart murmur ☐ Congestive heart failure ☐ High blood pressure ☐ Aortic aneurysm ☐ Other heart problem ☐ **Pacemaker** ☐ **Defibrillator** ☐ Other_____	☐ Leg pain walking over 1 block ☐ Leg pain walking less than 1 block ☐ Pain in legs while at rest ☐ Blood clots in legs ☐ Deep ☐ Superficial ☐ Cold feet or hands ☐ Amputation of toes ☐ Amputation of feet or legs ☐ Peripheral vascular disease ☐ Ulcers of lower legs ☐ Varicose veins ☐ Aneurysm of arteries ☐ Other _____	☐ Diarrhea ☐ Constipation ☐ Stool changes ☐ Bowel habits changes ☐ Hemorrhoids ☐ Indigestion ☐ Ulcers ☐ Irritable bowel ☐ Colon polyps ☐ Cramps/ pains ☐ Cancer of the stomach or bowel ☐ Diverticulitis ☐ Other _____	☐ Hesitancy / urgency of urine ☐ Need to urinate often at night ☐ Loss of bladder control ☐ Difficult urination ☐ Renal failure ☐ Impotence ☐ Current Dialysis ☐ Renal transplant ☐ Prostate enlargement ☐ Cancer of bladder/ kidneys ☐ Other _____
Blood & Lymph System	**Eyes, Ears, Nose & Throat**	**Musculoskeletal**	**Skin**
☐ Anemia ☐ Blood disease ☐ Transfusions ☐ Leukemia ☐ Bone marrow test ☐ Long term Coumadin use ☐ Blood clotting problems ☐ Other _____	☐ Pain ☐ Hearing loss ☐ Polyps ☐ Vertigo ☐ Ringing in ears (tinnitus) ☐ Sinus infections ☐ Deafness ☐ Other _____	☐ Arthritis ☐ Joint swelling ☐ Joint stiffness ☐ Muscle aches ☐ Muscle weakness ☐ Leg cramps ☐ Other _____	☐ Rashes ☐ Tumors ☐ Sensitivity to sunlight ☐ Malignant melanoma ☐ Squamous cell carcinoma ☐ Basal cell carcinoma ☐ Easy bruising ☐ Fungal infections ☐ Non-healing sores ☐ Excessive rough or dry skin ☐ Other _____
Endocrine	**Abnormal Organs**		
☐ Thyroid problems ☐ **Diabetes – Type 1** ☐ **Diabetes – Type 2**	☐ Hepatitis ☐ Cirrhosis (Liver) ☐ Gallbladder disease	Height: _____ Weight: _____	

Medications – Please list all medications you are currently taking:

Name	Dosage	Name	Dosage

If you need additional space, Please use the back of this page.

Advanced Medical Centers

What Brings You To Our Office?

Patient Name: _____ Today's Date: _____

What is your major complaint?

_____
_____
_____

How long have you had this problem?

_____
_____

Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about? ☐ Yes ☐ No If so please describe:

_____
_____
_____

What have you tried for treatment that did not work?

_____
_____

Have you seen a M.D., P.T., or a D.C. for this problem?
☐ Yes ☐ No

Doctor's Name	Specialty	Year(s) Seen

How does this problem interfere with your daily day life?

_____
_____
_____

Have you been worried about getting this problem resolved?
☐ Yes ☐ No If yes, please describe:

_____
_____
_____

What is your main concern about your symptoms?

_____
_____
_____

On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

	0	1	2	3	4	5	6	7	8	9	10

ADVANCED MEDICAL CENTERS

Notice of Privacy Practices/Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change in accordance with Federal regulations. You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed. We are not required to agree to this restriction, but if we do, we are bound by our agreement. Any request to restrict our use of your information must be done in writing to Advanced Medical Centers at 15521 Midlothian Turnpike #402 Midlothian, VA 23113. Advanced Medical Centers intends to use and disclose the minimum necessary PHI about you for treatment, payment, or health care operations. Other uses and disclosures not described as permitted in our Notice of Privacy Practices will require a current signed and dated authorization from you or your legal appointed representative. By signing below, you are stating that you have been provided a copy of the Notice of Privacy Practices for Advanced Medical Centers.

Patient's Authorization to Release Medical Information/Leave Messages

You understand that your relative(s)/friend(s) may ask questions about your medical information via mail, email, text, phone or in person. You also understand it is a breach of practitioner-patient confidentiality for your practitioners to discuss your medical information in any way with anyone without your expressed written consent. You hereby authorize Advanced Medical Centers to discuss your medical information to the designated individual(s) listed below. You request to have your PHI provided to you by messages from Advanced Medical Centers. Communication concerning your PHI may be provided by mail, email, text, and voicemail to you and to the designated individuals(s) listed below. You understand this form will remain in effect unless revoked by you in writing.

Designated Individual(s) and Phone Numbers:

_____

_____

Authorization for Medical Treatment

By signing below, you authorize and consent to health care services or supplies including, but not limited to, diagnostic procedures, therapy, and medical treatment either by or under the supervision of the doctor(s) in the office, who now or in the future treat you while employed by, working, or associated with, or serving as back-up for the doctor(s) at Advanced Medical Centers. You acknowledge that no guarantee or promises have been made to you as to the result to be obtained from such services. You have the right to refuse treatment and/or supports after your provider has given you adequate explanation. You understand and have been informed that in the practice of medicine there are some risks to treatment. You do not expect the provider to be able to anticipate and explain all risks and complications, and you wish to rely on the provider to exercise judgment during the course of the procedure which the provider feels at the time, based upon the facts then known, is in your best interests. You intend this consent form to cover the entire course of treatment for your present conditions(s) and for any future condition(s) for which you seek treatment.

Patient Name:_____

Patient Signature:_____ Date:_____

ADVANCED MEDICAL CENTERS
Records Release Authorization

Patient Name (please print):_____

Date of Birth:_____/_____/_____ SSN:_____

I hereby authorize and request (Name of Doctor's Office / Hospital / Doctor's Name):

_____

to release my medical records to:

Advanced Medical Centers
15521 Midlothian Turnpike #402
Midlothian, VA 23113
Phone: (804) 594-7272
Fax: (804) 381-4452

Information to be released:
☐X-rays/MRI Reports ☐Surgical Records

Conditions:
☐Low back ☐Neck ☐Hips ☐Shoulder ☐Knees ☐Other_____

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Advanced Medical Centers has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to Advanced Medical Centers at the address listed above.

I understand that once this information is released by Advanced Medical Centers, the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law.

Patient's Signature: _____ Date: _____