ADVANCED MEDICAL CENTERS

New Patient Intake Form

Patient Information

Date: _____ File #: (office use) _____

Name: _____

E-Mail :_____

Phone:_____ Cell:_____

Address: _____

_____,_____,_____

City State Zip

Sex: ❑M ❑F Age: _____ DOB:____/____/_____

❑Single ❑Married ❑Widowed ❑Separated ❑Divorced

SSN:_____

Occupation:_____

Employer:_____

Spouse's Name:_____

Spouse's Employer: _____

Family Physician: _____

Office Use Only: (Circle What Applies)

Patient Records

Pt. brought disc or hard copies:

X-Ray MRI CT Report Other: _____

Need to Request:

X-Ray Images **X-Ray Report**

MRI Images **MRI Report**

CT Images **CT Report**

Date of Records: _____

Location: _____

Physician: _____

Take X-Rays **Staff Initials: _____**

How did you hear about us?

❑Referral from doctor:_____

❑Referral from patient:_____

❑Television channel:_____

❑Internet website:_____

❑Newspaper:_____

❑Other:_____

Chief Complaint (Write Down Your #1 Chief Complaint)

#1 Chief Complaint: _____

Date of Injury/Onset of Pain: _____

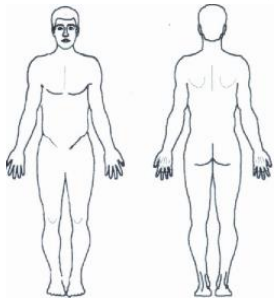
Is this condition getting progressively worse? ❑Yes ❑No ❑I Do Not Know

Circle on the pictures to the right where you have symptoms: →→→→→

Do your symptoms radiate to:

❑Shoulders ❑Arms ❑Hands ❑Fingers ❑Legs ❑Feet ❑Knees

Circle #1 Chief Complaint Only



Type of Symptoms:

❑Sharp ❑Dull ❑Numb ❑Aching ❑Stiff ❑Shooting ❑Throbbing ❑Burning ❑Tingling ❑Cramping ❑Swelling ❑Decreased Balance ❑Other_____

How often do you have the symptoms?_____

Is it constant? ❑Y ❑N Comes and goes? ❑Y ❑N

What makes the symptoms worse? _____ Better? _____

Does it interfere with your…? ❑Work ❑Sleep ❑Daily Routine ❑Hobbies

Activities/movements that are painful? ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying down

How Bad Do You Need Help (Circle)? **Not Really-- 0 1 2 3 4 5 6 7 8 9 10 --Urgent!**

Surgical History ❑ I **DO NOT** have a history of any previous surgeries.

Type of Surgery/Year/Surgeon?_____

_____

Treatment History

Past treatments for this condition? ❑Medication ❑Physical Therapy ❑Chiropractic ❑Injections ❑Acupuncture ❑Other _____

Doctors you've seen for this condition: ❑Family Doctor ❑ Neurologist ❑Endocrinologist ❑Podiatrist ❑Vascular Specialist ❑Rheumatologist ❑Orthopedist ❑Cardiologist

Past Medical History		**Coronary Art. Dis.**	☐**Y** ☐**N**	**Cold Feet**	☐**Y** ☐**N**
Alcoholism	☐Y ☐N	Depression	☐Y ☐N	**Cold Hands**	☐**Y** ☐**N**
Anemia	☐Y ☐N	**Diabetes**	☐Y ☐N	**Leg Pain / Walking**	☐**Y** ☐**N**
Anxiety	☐Y ☐N	Epilepsy/Seizure	☐Y ☐N	**Muscle Weakness**	☐**Y** ☐**N**
Arthritis	☐Y ☐N	Gout	☐Y ☐N	**Leg Cramps**	☐**Y** ☐**N**
Asthma	☐Y ☐N	Headaches	☐Y ☐N	Osteoporosis	☐Y ☐N
Atrial Fibrillation	☐**Y** ☐**N**	**Heart Disease**	☐**Y** ☐**N**	Pacemaker	☐Y ☐N
Bladder Problems	☐Y ☐N	Hemophilia	☐Y ☐N	Parkinson's	☐Y ☐N
Blood Clots-legs	☐**Y** ☐**N**	Hepatitis A / B / C	☐Y ☐N	Prostate Issues	☐Y ☐N
Blood Clots-lungs	☐Y ☐N	Hernia	☐Y ☐N	Psychological Dis.	☐Y ☐N
Blood Pressure-high	☐**Y** ☐**N**	Herpes	☐Y ☐N	Recurrent Infection	☐Y ☐N
Blood Pressure-low	☐Y ☐N	HIV/AIDS	☐Y ☐N	STD	☐Y ☐N
Bowel Issues	☐**Y** ☐**N**	**Kidney/Renal Dis**	☐**Y** ☐**N**	**Stroke CVA / TIA**	☐**Y** ☐**N**
Cancer _____	☐**Y** ☐ **N**	Liver Disease	☐Y ☐N	Thyroid	☐Y ☐N
Cong. Heart Failure	☐**Y** ☐**N**	Lung Problems	☐Y ☐N	**Ulcer on Foot/Leg**	☐**Y** ☐**N**

Current Medications: ❑**See List (I am attaching my medication list)**

❑Statin/Cholesterol ❑Blood Pressure Med. ❑Blood Thinner ❑Blood Sugar Med. ❑Insulin

Social History Exercise? ❑None ❑Moderate ❑Daily Children? ❑Yes ❑No

Habits? Smoking # packs/day_____ Alcohol # drinks/day_____ Coffee/Caffeine # cups/day_____

Current Review of Body Systems (Please check box if **NORMAL**)

Normal	**Problem Details**	**Normal**	**Problem Details**
❑Musculoskeletal	_____	❑Stomach	_____
❑General Health	_____	❑Bladder	_____
❑Eyes	_____	❑Blood	_____
❑Ears/Nose/Throat	_____	❑Neurological	_____
❑Thyroid	_____	❑Psychiatric	_____
❑Breathing	_____	❑Skin	_____
❑Heart	_____	❑Allergic	_____

Are You Pregnant? ❑Y ❑N **Are You Nursing? ❑Y ❑N**

Initial on the Lines Below (You will not be seen by the provider without initialing and signing)

_____ I make my own medical/financial decisions

_____ I do **NOT** have a Durable Power of Attorney (A person in charge of my **medical** decisions)

_____ I do **NOT** have a Financial Power of Attorney (A person in charge of my **financial** decisions)

By signing below, I assume full responsibility that all information is accurate, this is my consent for examination and treatment, and I agree to inform this office of any changes in my personal medical status.

Patient Signature: _____ Date: _____

TURN TO NEXT PAGE

ADVANCED MEDICAL CENTERS

Artery and Nerve Inflammation Questionnaire

Name: _____ Date: _____

1.	Are your feet sensitive to touch, such as under the bedcovers?	☐Y	☐N
2.	Are your symptoms worse at night, watching TV or during bedtime?	☐Y	☐N
3.	Do your feet/legs hurt when you walk, and feel better when resting?	☐Y	☐N
4.	While in the shower, is it hard to tell hot water from cold water on your legs/feet?	☐Y	☐N
5.	Are your hands and/or feet cold a lot of the time?	☐Y	☐N
6.	Have you ever had an open sore(s) on your foot or leg in the past?	☐Y	☐N
7.	Do you currently have an open sore(s) on your foot or leg?	☐Y	☐N
8.	Is the skin on your feet/legs so dry that it flakes or cracks open?	☐Y	☐N
9.	Is the skin on your feet/legs shiny?	☐Y	☐N
10.	Do you have hair loss on your legs/feet?	☐Y	☐N
11.	Do you have unusual redness or dark spots on your legs/feet?	☐Y	☐N
12.	Are your toenails discolored or brittle?	☐Y	☐N
13.	Do you have pain, burning, tingling or numb fingers/hands?	☐Y	☐N
14.	Are you losing grip strength in your hands?	☐Y	☐N
15.	Do you have problems with your balance?	☐Y	☐N
16.	Do you have pain shooting down from your low back into your legs/feet?	☐Y	☐N
17.	Do you have pain shooting down from your neck into your arms/hands?	☐Y	☐N
18.	Can you stand up from a chair without using your hands to pull yourself up?	☐Y	☐N
19.	Do you struggle putting your shoes on because you can't reach your feet easily?	☐Y	☐N
20.	Have you noticed that your symptoms are progressively getting worse?	☐Y	☐N
21.	Is your sleep being affected because of your symptoms?	☐Y	☐N
22.	Does it feel as if you're losing your Quality of Life because of your symptoms?	☐Y	☐N
23.	Are you becoming frustrated that you haven't gotten the help you need?	☐Y	☐N
24.	Does it feel like friends, family, and doctors don't understand your struggle?	☐Y	☐N
25.	Are you willing to work with us to finally get the relief that you deserve?	☐Y	☐N

ADVANCED MEDICAL CENTERS

"We help you get fast relief from your symptoms, even when every other doctor is unable to."

If you're tired of just covering up your symptoms with drugs, injections, and surgery… You're finally in the right place!