ADVANCED HEALTH SERVICES, LLC
Email: advancedhealth14@gmail.com
Website: www.OurAdvancedHealthServices.com
Phone: 561-596-7581 FAX: 561-355-5155

CLIENT INFORMATION

Please, print

Name:______________________________ DOB: __________ Social Security #: _________________

Address: ____ City:________________ State: ________

Zip Code: _________ Telephone: ____________________ Cell Phone: ______________________

Sex: __ Male __ Female Marital Status: __Single __ Married __ Widowed __Divorced __ Separated

E-mail Address: _________________________________ Referred By:_________________________

Employed by: ___________________________________ Business Telephone:___________________

Employer's Address: _____________________________ City___________________ State ________

Zip Code: _______________ Occupation ____

Spouse or Parent Name:____________________________ Telephone # _________________________

Who is responsible for this account? ____

Card Holder's Name: ____

Type of Credit card: ______________________________ Credit Card #:_______________________

Expiration Date: _______________ Cid # / V code: ___________ Billing Zip Code: _______________

Emergency Contact:_______________________________ Telephone #:_________________________

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, unless other arrangements are made in advance. I understand that I am financially responsible for any charges incurred in the collection of this account, should I default on payment. Such charges include, but not limited to legal fees, collection fees or late charges.

Signature of Client or Legal Representative:______________________________ Date: _________________

HEALTH HISTORY

Name: ______________________________ Date: ______________
Present Problem: ______________________ Duration: __________
Chief Complaint: ______________________ Duration: __________
Other Complaints: _____________________ Duration: __________

MEDICAL HISTORY:	YES	NO
Heard Disease	___	___
Pneumonia	___	___
Fainting	___	___
Headaches	___	___
Back pain	___	___
Bleeding Problems	___	___
Chronic Lung Disease	___	___
Gallbladder Disease	___	___
Indigestion	___	___
Hernia	___	___
Bladder / Kidney Disease	___	___
Stomach/Liver/Pancreas problems	___	___

FAMILY MEDICAL HISTORY	YES	NO
Stroke	___	___
Diabetes	___	___
Headaches	___	___
Rheumatic Arthritis	___	___
Gout	___	___
Muscle or Nerve Disorder	___	___
Easy Bleeding	___	___
Seizure Disorder	___	___

MEDICATIONS: Please list Names & Dosages
____
____
____
____

MEDICATION ALLERGIES:	YES	NO
Penicillin	___	___
Aspirin	___	___

Other: ______________________________
FOOD ALLERGIES: Please List __________
____
____

Previous Operations & in what year:
____
____
____
____
____
____

Date of Last Menstrual Period: __________
Do you smoke? Yes ______ No______
If yes, How many per day? __________
How many years? __________
Alcohol Consumption? Yes ______ No______

Amount: __________Frequency:__________

DO YOU CURRENTLY HAVE:	YES	NO
Recent change in vision	___	___
Chronic cough	___	___
Chest pain	___	___
Palpitations	___	___
Shortness of breath	___	___
High blood pressure	___	___
Low blood pressure	___	___
Asthma	___	___
Emphysema	___	___
Lowered sex drive	___	___
Menopause	___	___
If yes, at what age __________		
Difficulty controlling urination	___	___
Recent weight loss	___	___
Recent weight gain	___	___
Changes in bowel habits	___	___
Black stools / Blood in stools	___	___
Nausea or Vomiting	___	___
Abdominal pain	___	___
Fatigue / Easy tiredness	___	___
Sleep difficulty	___	___
Nervousness	___	___
Depression	___	___
High / Low body temp.	___	___
Weakness	___	___
Headaches	___	___
Location __________		
Frequency __________		
Numbness	___	___
If yes, where? __________		

Prior Treatment for Present Problems:
____

Traditional Treatment Prognosis:
____
____
____
____
____
____