AHS
Advanced Healthcare Solutions
Feel better. Look better. Live better.

Phone: 440-624-4214
Fax: 440-624-4299
1484 Rt.46 Ste.7
Jefferson, OH 44047
www.adhcsolutions.com

Confidential Case History

Patient Information:

Date:________________ Social Security Number:_____-_____-_______

Name:____

Last First MI

Address:____

Number & Street P.O. Box. City State Zip

Telephone:(Home)______________(Cell)_______________(Work)________________

Email Address:___________________________________

Date of Birth:_____/_______/_________ Age:_______

Gender: M F Marital Status: S M D W Number of Children:_________

Occupation:______________

Employer:_________________ Address:___________________________________

NEAREST FRIEND OR RELATIVE WHO MAY BE CONTACTED IN CASE OF AN EMERGENCY:

Name:____________________ Phone:_____________________________

How did you hear about Advanced Healthcare Solutions?:____________________

Is your condition the result of an accident or job related injury?_______Yes ________No

AHS POLICY REGARDING PAYMENT AND INSURANCE REIMBURSEMENT

I understand and agree that I'm paying Advanced Healthcare Solutions for all services rendered at the time of service. AHS provides expert health knowledge, guidance, opinion on your healthcare and holistic treatments. AHS is dedicated to keeping you, the client as healthy as possible. Furthermore, I understand that because of this, pay for fee service, *absolutely no* health information will be given to your insurance provider, unless with your written consent. If you do have insurance, Advanced Healthcare Solutions will provide you a receipt for services rendered that you can submit to your insurance for ***possible*** reimbursement. This does not guarantee full or any reimbursement. That is the extent of assistance. No copies or duplicates will be made past receipts. Advanced Healthcare Solutions does not work with or for insurance companies. We direct our time and focus into client service. We pride ourselves on customized goal-oriented nutritional and wellness programs that produce exemplary results. Advanced Healthcare Solutions long-term goal is disease eradication and keeping our clients as healthy as possible throughout their life.

I have read and understand the above:

Signature ____ Date ________________

I will be paying by _______Cash______Check_______Credit Card
______MasterCard_____Visa______Discover______Other
Card #________________________ Exp. Date___________________

Signature:______________________________________ Date:_________________

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Confidential Health History

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any that apply to you:

___Pain Location____
___Numbness and tingling Location____
___Arthritis Location____
___Spinal or Anatomical deformity
Location__________________________________
___Skin issue Location____
___Stomach / Intestinal issue Type________________ Medication_____________
___Has inside pets ____Eats raw meats or sushi
___Traveled outside the U.S. ____History of food poisoning
___Normal bowel movements ____Daily ___Brown ____Well formed
___Lives/works around gas, oil refinery, chemicals, dyes, plastics, pesticides, machinery
___Drinks water Amount and type per day___________________
___Uses microwave or plastics
___Poor sleep Sleep pattern/Hours_______________________
___Weight Trouble Current weight________ Ideal weight__________
___Stress Reason____
___Interested in health, vitamins, nutrition and improving diet
___Allergies Type____
___Cardiovascular issue Type____
___Stroke Year_____ Medication____
___High Blood Pressure Medication______________________________________
___High Cholesterol Medication____
___Gastric Reflux / Heartburn Medication__________________________________
___Gallbladder issue Removed when? (Age/Year)__________________________
___Diabetes Medication____
___Liver issue Type___________________ Medication______________
___Lung issue Type___________________ Medication______________
___Kidney issue Type___________________ Medication______________
___Hormonal issue Type___________________ Medication______________
___Thyroid issue Type___________________ Medication______________
___Bladder issue Type___________________ Medication______________
___Ovary / Uterus issue Type___________________ Medication______________

___Prostate / Testicle issue Type___________________
Medication_______________
___Autoimmune Disorder Type___________________ Medication_______________
___Fibromyalgia Medication____
___Attention Deficit / Spectrum Disorders Medication__________________________
___Osteopenia / Osteoporosis Medication_________________________________
___Blood Disorder Type___________________ Medication_______________
___Cancer Type___________________________ Date of Remission_____________
___HIV Positive / AIDS
___Fibroids Location_____________________ Was surgery needed? Y N
___Endometriosis Was surgery needed? Y N
___Organ or Body Part Removed Type___________________ Year_____________
___Multiple infections in one year Type___________ Medication_________________
___Mental Disorder Type___________________ Medication______________
___Currently pregnant Trimester 1 2 3

Other unlisted ailments ____

Exercise	Work Activity	Habits (even if former)	
____None	_____Sitting	_____Smoking	Packs/day______
____Moderate	_____Standing	_____Alcohol	Drinks/week_______
____Daily	_____Light Labor	_____Coffee/Caffeine	Cups/day_________
____Heavy	_____Heavy Labor	_____Illegal drug use	Type___________

Do you drink soda or energy drinks? ___Yes ____No Drinks/week________
Other than listed above, any other:
Current Medications:____
Supplements/Nutrition:____
Hospitalizations/Operations:____
Fractures/Dislocations/Sprains:____
Severe Trauma/Accident/Falls (ex. Car accident,etc.)___________________________

FAMILY HISTORY

Include information on brothers, sisters, parents,grandparents. **DO NOT INCLUDE YOURSELF.**

___Diabetes ___ High Blood Pressure ___ Food Allergies ___Cancer ___Alcoholism
___Thyroid/Goiter ___Heart Disease ___ Kidney Disease ___ Depression ___Obesity

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST SIX MONTHS:

Musculoskeletal
___Low Back Pain
___Pain Between Shoulders
___Neck Pain
___Arm Pain
___Joint Pain/Stiffness
___Walking Problems
___Difficulty Chewing/Clicking Jaw
___General Stiffness

General
___Fatigue
___Allergies
___Loss of Sleep
___Fever
___Headaches

Nervous System
___Nervous
___Numbness
___Paralysis
___Dizziness
___Forgetfulness
___Confusion/Depression
___Fainting
___Convulsions

___Cold/Tingling Extremities

Genito-Urinary
___Bladder Trouble
___Painful/Excessive Urination
___Discolored Urine

Gastrointestinal
___Poor/Excessive Appetite
___Excessive Thirst
___Frequent Nausea
___Vomiting
___Diarrhea
___Constipation
___Hemorrhoids
___Abdominal Cramps
___Gas/Bloating after meals
___Heartburn
___Tan/Black/Bloody Stools
___Colitis

EENT
___Vision Problems
___Dental Problems
___Sore Throat
___Ear Aches
___Hearing Difficulties

___Stuffed Nose / Sinuses

CVR
___Chest Pain
___Short Breath
___Blood Pressure Problems
___Irregular Heartbeat
___Heart Problems
___Lung Problems/Congestion
___Varicose Veins
___Ankle Swelling
___Stroke

Male
___Prostate/ Sexual Dysfunction
___Other Problems __________

Female
___Menstrual Irregularities
___Menstrual Cramps
___Vaginal Pain/ Infection
___Breast Pain/ Lumps
___Sexual Dysfunction
___Decreased Libido
When was your last period?__________

Signature:______________________________ Date:____________

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Informed Consent to Treat

State law requires us to obtain your informed consent before starting treatment:

I, ________________________________, of ________________________(City/State) do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. I have made my decision voluntarily in freely. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are other risks and possible complications associated with these procedures as follows:

Soreness: I'm aware that I may experience soreness in the first few treatments.

Fractures / joint injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis or other abnormalities are detected, Advanced Healthcare Solutions proceeds with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. I'm aware that this serious side effect is reported to occur once in 10 million treatments. Once in 10 million is about the same chance as aspirin or Tylenol causing death. Once in 1 million are the same odds of getting hit by lightning.

Dizziness: Temporary symptoms like dizziness and nausea are also rare.

Burns: Some of the machines used in this office generate heat may rarely cause a burn. Despite precautions, if a burn is obtained, there'll be a temporary increase in pain and possible blistering. This should be reported to the Doctor.

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, exercises and possible surgery and/or education.

Medications: Medications can be used to reduce pain or inflammation. I am aware that long term or overuse of medication is always a cause for concern. Drugs may mask pathology, produced inadequate or short form relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risk. At no time will Advanced Healthcare Solutions recommended any changes to medications. Questions about your medications need to be answered by your prescribing physician.

Rest / Exercise: bed rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. Same is true of home therapy exercises.

Surgery: surgical risks may include unsuccessful outcomes, complications, pain, reactions to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar and adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening of pathology. The affirmation may complicate treatment making recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction **prior to my signing this consent form.** To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of patient:_________________________________ Date/Time:__________________

Signature of witness:_________________________________

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HIPPA

I consent to the use or disclosure of my protected health information by Advanced Healthcare Solutions for the purpose of analyzing, diagnosing or providing treatment to me. I understand that analysis, diagnosis or treatment of me by Advanced Healthcare Solutions may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction to how my protected health information is used or disclosed to carry out treatment or healthcare operations of Advanced Healthcare Solutions. Advanced Healthcare Solutions is not required to agree to the restrictions that I may request. However, if Advanced Healthcare Solutions agrees to a restriction that I request, the restriction is binding on Advanced Healthcare Solutions. Advanced Healthcare Solutions will never share my health or personal information without my written consent.

I have the right to revoke this consent, in writing, at any time, except to the extent that Advanced Healthcare Solutions has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse, will never be shared and always kept secure. This protected health information relates to my past, present or future physical and mental health or condition that identifies me, or reasonable basis to believe the information may identify me.

Upon request, I can be provided with a copy of the Notice of Privacy Practices of Advanced Healthcare Solutions and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment or in the performance of health care operations of Advanced Healthcare Solutions. The Notice of Privacy Practices also describes my rights and duties of Advanced Healthcare Solutions with respect to my protected health information.

24 Hr. Cancellation Policy
440-624-4214

(Please store this number in your phone)

Advanced Healthcare Solutions has a 24 hour cancellation / rescheduling policy. If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged the amount of your scheduled visit. This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to be treated.
By signing below, you acknowledge that you have read and understand the Cancellation Policy for Advanced Healthcare Solutions as described above.
Thank you for your understanding and cooperation.

______________________________ ______________________________

Signature of Patient or Personal Representative Printed Name of Patient

____________ __________________________________

Date of Signing Description of Personal Representative’s Authority