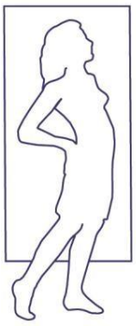

ADVANCED CHIROPRACTIC CENTER, INC.

Specializing in: Sports
Automobile
& Work Injuries

DR. DEAN A. ROLL

Patient Data

Name_____Date_____Email
_____
Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address_____City_____State_____Zip Code
_____Telephone (work)_____(home)_____Referred By _____
Age_____Birth date_____Social Security #_____Number of children _____
Occupation _____
Employer_____
Marital Status_____Spouse's name_____Spouse's Occupation
_____
Spouse's employer_____Spouse's health status _____
Emergency contact_____Phone _____

Current Complaints

Nature of injury: Automobile* ❑ Work ❑ Other ❑
Please describe
_____

_____

Date of injury_____Date symptoms appeared _____
Have you ever had same condition? ❑ No ❑ Yes If yes, when?
_____
List other practio
ners seen for this injury/condition _____
Have you ever been under chiropractic care? ❑ No ❑ Yes
If yes, please describe
_____

Insurance Information

Name of party responsible for payment_____Phone_____
Do you have health insurance? ❑ No ❑ Yes Name of company _____
*** If an auto accident please provide:**

Insurance company name_____Contact person
_____
Phone_____Claim #
_____

2508 Hillsboro Avenue • Golden Valley, MN 55427 • 763-542-1141

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature_____Date_____
Spouse's or guardian's signature_____Date _____

Medical History

Have you been treated for any conditions in the last year? ❑ No ❑ Yes
If yes, please describe _____
Date of last physical exam_____. Is there a chance that you are pregnant? ❑ No ❑ Yes
Have you had X-rays taken? ❑ No ❑ Yes If yes, where? _____
What medications are you taking and for what conditions (Please list dosage and amounts, etc).
_____
_____
_____
What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	❑	❑	_____
Been hospitalized?	❑	❑	_____
Been in an auto accident?	❑	❑	_____
Had Sprains/Strains?	❑	❑	_____
Been struck unconscious?	❑	❑	_____
Had surgery?	❑	❑	_____

Family History	
Family Member	**Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

Do you experience pain every day?	❑ No ❑ Yes
Do your symptoms interfere with daily life?	❑ No ❑ Yes
Does pain wake you up at night?	❑ No ❑ Yes
Are your symptoms worse during certain times of the day?	❑ No ❑ Yes
Do changes in weather affect your symptoms?	❑ No ❑ Yes
Do you wear orthotics?	❑ No ❑ Yes
Do you take vitamin supplements?	❑ No ❑ Yes
What activities aggravate your symptoms?	❑ No ❑ Yes

Habits	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑

Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain/Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems/insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other **B**=Burning
P=Pins & Needles
N=Numbness **S**=Stabbing