Continuum
Advanced Healthcare

First Name_____**MI**____**Last Name**_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____Work/Alt (_____)_____Ext_____

Cell Phone (_____)_____**Date of Birth**_____/_____/_____**Age**_____

Social Security #_____ Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Significant Other

Emergency Contact: _____ Phone: _____

Do you have health insurance? ☐ Yes ☐ No Employer: _____

Employment Address: _____

Employer Phone: (_____)_____

Primary Insured: _____ Ins. Company: _____

ID#: _____ Group#:_____Phone: (_____)_____

Claims Address: _____

Is your visit due to :

Workers Compensation		Social Security Disability (SSDI)		None	
Motor Vehicle Accident/Motorcycle Accident		Slip and Fall			

Have you contacted an Insurance Adjuster? ☐ Yes ☐ No Date of Accident_____/_____/_____

Are you receiving care elsewhere? ☐ Yes ☐ No Where?_____

Auto Insurance Company_____Phone #_____

Adjustor Name_____Claim #_____

Do you have an attorney? ☐ Yes ☐ No Attorney Name_____ Phone _____

Address_____Paralegal_____

Name: _____ DOB: ____/____/____ DOS: _____/_____/_____

Current Information:

History: Accident_____ Injury_____ Date_____/_____/_____ Time: _____

Please indicate the following claims you have filed related to your pain problem:

Occupation:_____Do you need a work slip? YES / NO

Currently: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Unemployed ☐ Retired
☐ Disabled and unable to work ☐ Homemaker

The last date I worked was:_____/_____/_____
I have been on disability since:_____/_____/_____

Medications

List all of your medications, dosages and how often you take them every day and when you started taking them:
Ex: 80mg Aspirin 1 x daily, 1999

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10._____

Drug Allergies or sensitivities

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Medical History

Do you have or have you had any of the following?

CONDITIONS	YES	NO	Conditions	YES	NO
Any contagious disease			Lung disease (asthma/COPD, etc)		
Bleeding problems			Kidney disease		
Cancer			Rheumatoid arthritis		
Osteoarthritis			Psoriatic arthritis		
Fibromyalgia			Arthritis		
Diabetes			Seizure disorder		
Heart disease or chest pain			Stomach disorders		
High blood pressure			Suppressed immune system		

Neurological disorders			Thyroid disease		
Liver disease (hepatitis, ascites)					
GENERAL					
Insomnia			Fevers		
Fatigue			Weakness		
Chills			Low Sex Drive		
Headaches			Weight Gain/Loss		
Bruise easily			Tremors		
SKIN and HAIR					
Hives			Rashes		
Loss of hair			Ulceration		
Itching					
EENT					
Eye problems			Ringing in Ears		
Hearing Problems			Nose Bleeds		
Headaches			Earaches		
Sinus problems			Recurrent sore throat		
Dental problems			Thyroid problems		
Head injury					
CARDIOVASCULAR					
Chest Pain			Poor circulation		
Heart attack			Murmur		
Stroke			Irregular heart beat		
Swelling of feet			MVP		
Valve replacement			Phlebitis		
Pacemaker			Fainting		
High blood pressure			High cholesterol		
RESPIRATORY					
Wheezing			Cough		
Short of breath			Valley fever		
Emphysema			Bronchitis		
Difficulty breathing			Rib pain		
Pneumonia			Tuberculosis		
CONSTITUTIONAL					
Nausea/Vomiting			Acid reflux		
Bleeding			Recurring infections		
Abdominal pain			GI Bleeding from medications		
Bowel/Bladder Control			Diarrhea		
Constipation					
RENAL					
Dialysis			Kidney infection		
Bladder infection			Kidney problems		

If you answered yes to any of the above, or if you have any other medical problems, please explain: