PATIENT INFORMATION

ATLANTA CHIROPRACTIC & WELLNESS CENTER

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Full Name _____ Date:_____

Address: _____ City_____ State_____ Zip_____

SSN: _____ Marital Status (Circle One): **S M W D Sep** No. Children: _____

DOB: _____ Age: _____ Home Phone: _____

Cell Phone: _____ Cell Carrier: _____

Email _____ Contact Preference: Cell / Email (Circle One)

Your Employer _____Your Occupation _____Years on Job _____

Name of Spouse, Parent or Guardian:_____ Age:_____ DOB:_____

Spouse/Parent/Guardian Phone: _____

Spouse/Parent/Guardian Email: _____

How did you find out about our office? _____

Who is your Medical Doctor?_____ Phone: _____

Is your condition due to an accident? ☐**Yes** ☐**No** (Circle One)

IF Yes--- Date of your accident: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care pan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original. I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature_____ Date _____

Spouse's or Guardian's Signature _____ Date _____

We have a 24 hour cancellation policy. Llate cancellation or no show to an appointment will result in a fee of $25. Please initial to acknowledge: _____

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FULL NAME_____ DATE_____

AGE_____ HEIGHT_____ WEIGHT_____

WHAT IS YOUR CHIEF COMPLAINT?_____

NO PHYSICAL COMPAINTS AT THIS TIME: ☐

☐ Confusion	☐ Neck Pain	☐ Lower Back Pain
☐ Depression	☐ Neck Restriction	☐ Lower Back Stiffness
☐ Dizziness	☐ Neck Stiffness	☐ Constipation
☐ Blurred/Double Vision	☐ Pins & Needles in Arms: (Circle one) Right Left Both	☐ Pins & Needles in Legs: (Circle one) Right Left Both
☐ Ears Ringing/Buzzing	☐ Pins & Needles in Hands: (Circle one) Right Left Both	
☐ Eye Strain/Pain	☐ Shoulder Pain: (Circle one) Right Left Both	
☐ Fainting	☐ Elbow Pain: (Circle one) Right Left Both	
☐ Fear	☐ Hand Pain: (Circle one) Right Left Both	
☐ Headache	☐ Knee Pain: (Circle one) Right Left Both	☐ Other:
☐ Head Seems Heavy	☐ Ankle Pain: (Circle one) Right Left Both	
☐ Irritability	☐ Foot Pain: (Circle one) Right Left Both	
☐ Loss of Memory	☐ Upper Back Pain	
☐ Loss of Smell	☐ Upper Back Stiffness	
☐ Loss of Taste	☐ Rib Pain	
☐ Mental Dullness	☐ Mid-back Pain	
☐ Nervousness	☐ Mid-back Stiffness	
☐ Tension	☐ Chest Pain	
☐ Unbalanced	☐ Feet/Hands Cold	

HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENT IN THE LAST YEAR? YES ☐ NO ☐

IF SO, IS THIS CONDITION RELATED? YES ☐ NO ☐

HAS THE PROBLEM INTERRUPTED YOUR SLEEP? YES ☐ NO ☐

DOES ANYONE IN YOUR FAMILY HAVE THE SAME OR SIMILAR CONDITION? YES ☐ NO ☐

IF SO, WHO: _____

LIST ANY OTHER DOCTORS OR THERAPISTS THAT YOU HAVE SEEN FOR THIS COMPLAINT:

_____

SPECIALTY:_____

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RELEVANT MEDICAL HISTORY:

(Please check the conditions you have or have had

☐ **Arthritis**	☐ **Epilepsy**	☐ **Muscular Dystrophy**	☐ **Stroke**
☐ **Asthma**	☐ **Fibromyalgia**	☐ Neck Pain or Spasms	☐ **TIA (mini stroke)**
☐ **Anemia**	☐ **Hand or Wrist Pain**	☐ Neuritis	**Additional Comments:**
☐ **Back Pain or Spasm**	☐ **Headaches**	☐ Numbness	
☐ **Cancer**	☐ **Heart Problems**	☐ Polio	
☐ **Concussion**	☐ **Hepatitis**	☐ Rheumatic Fever	
☐ **Convulsion**	☐ **High Blood Pressure**	☐ Sinus Trouble	
☐ **Diabetes**	☐ **HIV**	☐ Sciatica	
☐ **Digestion Problems**	☐ **Measles**	☐ Tuberculosis (TB)	
☐ **Dizziness**	☐ **Multiple Sclerosis**	☐ **Venereal Disease**	

LIST ANY SURGERIES THAT YOU HAVE HAD AND APPROXIMATE DATES:

1. _____ **DATE:** _____

   DR: _____

2. _____ **DATE:** _____

   DR: _____

3. _____ **DATE:** _____

   DR: _____

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FULL NAME_____ **DATE**_____

ARE YOU TAKING ANY MEDICATIONS FOR THIS OR ANY OTHER COMPLAINT? YES ☐ NO ☐

IF YES, PLEASE LIST: _____

ARE YOU TAKING ANY SUPPLEMENTS? YES ☐ NO ☐

IF YES, PLEASE LIST: _____

ARE YOU PREGNANT? YES ☐ NO ☐ IF YES, DUE DATE:_____

FAMILY HISTORY: HEART DISEASE ☐ ARTHRITIS ☐ CANCER ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐

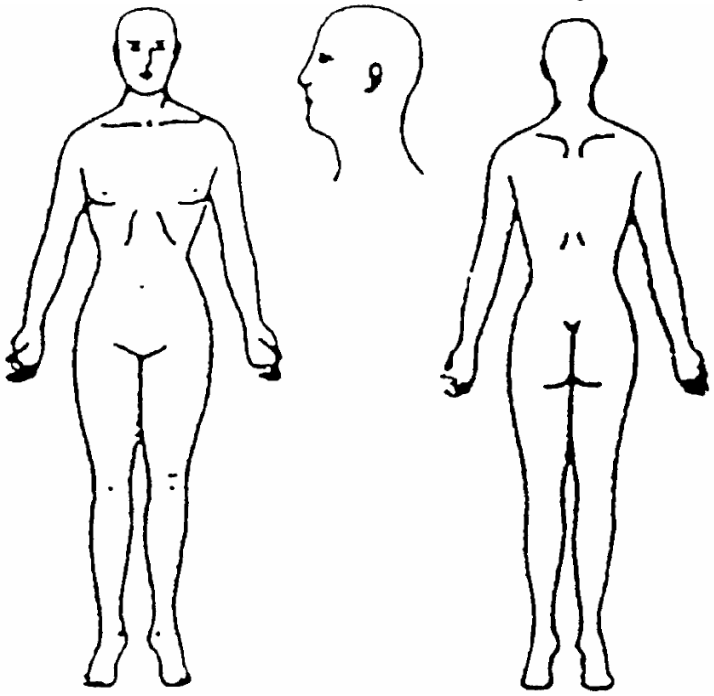
DO YOU: SMOKE: YES ☐ NO ☐ IF YES, AMOUNT PER DAY:_____

DRINK: YES ☐ NO ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐

DRUGS: YES ☐ NO ☐

SYMPTOMS DIAGRAM

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



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ON A SCALE FROM 1-10, 1 BEING THE LEAST AMOUNT OF SYMPTOMS AND 10 BEING THE WORST,

PLEASE INDICATE THE SEVERITY REGARDING THE FOLLOWING QUESTIONS:

How bad are your symptoms now?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
How bad have they been in the past?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What are the symptoms at their worst?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What are the symptoms at their best?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
How bad are your symptoms on average?	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

ARE YOU HERE FOR :

RELIEF CARE ☐

(Gets rid of symptoms or pain, but not cause)

CORRECTIVE CARE ☐

(Gets rid of symptoms and corrects cause. Varies in length of time, but is more lasting.)