Advanced Chiropractic
35 Jackson Street.
Newnan, Ga. 30263 770-253-5040

Confidential Patient Health Record

Creating Optimal Health Through Chiropractic and Nutrition

Personal Information

Title: □ Mr. □ Ms. □ Mrs. □ Dr. □ Rev. □ Miss □ Prof. □ other: _____

Name:_____ **DATE: ____/_____/_____**
First Middle Last

Address: _____Apt # _____

City: _____ State:_____ Zip: _____ Country:_____

Home Phone: (_____) _____-_____ ext _____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ ext _____

Birth Date: _____ /_____/_____ Age:_____ Sex: Male/Female Social Security #: _____-_____-_____

Email Address: _____ Our office has an appointment reminder system using text or email; which do you prefer? (circle one) Email Text --If you choose text we need to know your cell phone carrier; here is the list of cell providers who participate: (circle one) Sprint, NexTel, Verizon, Cingular/AT&T, and T-Mobile

Marital Status: □Single □Married □Widowed □Divorced □Separated Spouse's Name: _____

Children (Names and Ages): _____

Race: □ African American □ Asian □ Caucasian □ Hispanic □ Multiracial □ Native American □ Other: _____

How did you hear about us? **□Family _____ □Friend _____**
□Co-Worker _____ □Insurance Plan □Internet/website □Yellow Pages □Yellow Book
□Drive by □Physician_____ □Other:_____

Emergency Contact:

Last:_____ First:_____ Middle: _____

Phone:(_____) _____-_____ ext ____ Relationship: □Spouse □Relative □Friend □Other _____

Employment Information

Business Name:_____Occupation_____

Location_____

Adult Illness(es): Check all health/past conditions. CIRCLE all CURRENT conditions.

□ ADD	□ cystic kidney disease	□ hypertension	□ psychiatric problems
□ alzheimers	□ depression	□ influenzal pneumonia	□ scoliosis
□ anemia	□ diabetes (insulin dep)	□ liver disease	□ seizures
□ arthritis	□ diabetes (non insulin)	□ lung disease	□ shingles
□ asthma	□ eczema	□ lupus erythema (discoid)	□past history of similar symptoms
□ cancer	□ emphysema	□ lupus erythema (systemic)	□ STD's (unspecified)
□ cerebral palsy	□ eye problems	□ multiple sclerosis	□ suicide attempt(s)
□ chicken pox	□ fibromyalgia	□ parkinson's disease	□ thyroid problems
□ crohn's/colitis	□ heart disease	□ unspecified pleural effusion	□ vertigo
□ CRPS (RSD)	□ hepatitis	□ pneumonia	□ other:
□ CVA (stroke)	□ HIV	□ psoriasis	

Name:_____ Date:____/_____/_____

If you have NO complaints check the box here □ and skip ahead to the next page.

What is your chief complaint? (WHY YOU ARE HERE, ONLY ONE COMPLAINT OR AREA OF COMPLAINT):_____

_____

When did this Condition BEGIN? ___/___/_____

Is the Condition: □ Auto Related □ Job Related □ Home Injury □ Slip or Fall □ Lifting □ Slept Wrong □ Gradual □ Repetitive □ Sudden □ Other Please explain:_____

_____

Has it ever occurred before? □ Yes □ No. When? _____

On a scale to 1-10, 10 being severe and 1 minimal, how would you rate this symptom?_____

What percentage of the day do you experience the symptom (1-100%), 10% being rare, 50% half of the day and 100% constant?_____

Please list any additional complaints in order of importance (pains/symptoms/illness/chronic disease)?

		G or S	1-10	1-100%
1)_____	**When did it start?_____**	**Gradual or Sudden_____**	**Severity_____**	**Percentage of day_____**
2)_____	**When did it start?_____**	**Gradual or Sudden_____**	**Severity_____**	**Percentage of day_____**
3)_____	**When did it start?_____**	**Gradual or Sudden_____**	**Severity_____**	**Percentage of day_____**
4)_____	**When did it start?_____**	**Gradual or Sudden_____**	**Severity_____**	**Percentage of day_____**
5)_____	**When did it start?_____**	**Gradual or Sudden_____**	**Severity_____**	**Percentage of day_____**

Daily Activities: Effects of Current Condition on Performance

Job Performance	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Bending:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Carrying:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Change Posn–Sit-Stand:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Climb Stairs:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Driving:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Extended Computer Use:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Feeding:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Household Chores:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Kneeling:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Lifting:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Reading:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Concentration:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Care–Bathing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Care–Dressing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Care–Shaving:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sleep:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sitting:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Standing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Walking:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Lying down:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Yard Work:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	□ **No Effect**	□ **Mild** Painful(Can do)	□ **Mod** Painful(limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful(Can do)	□ **Mod** Painful(limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful(Can do)	□ **Mod** Painful(limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful(Can do)	□ **Mod** Painful(limited)	□ **Sev** Unable to Perform

Name:_____ Date:____/_____/_____

*Rate each of the following symptoms based on your typical health profile.

Point Scale: 0—*Never or almost never* have the symptom **1—***Occasional*, effect is *not severe*

2—*Occasional*, effect is *severe* **3—***Frequent*, effect is *not severe* *4—Frequent, effect is severe*

HEAD
_____ Headaches/Migraines
_____ Faintness
_____ Troubles Sleeping
_____ Dizziness **TOTAL:**_____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
TOTAL:_____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____Ringing in ears, hearing loss
TOTAL:_____

NOSE
_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation
TOTAL:_____

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/discolored tongue, gums, lips
_____ Canker sores
TOTAL:_____

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss/increased facial/body hair
_____ Flushing, hot flashes
_____ Excessive sweating **TOTAL:**_____

HEART
_____ Chest pain
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
TOTAL:_____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
TOTAL:_____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____Interest in having sex is low/unable
_____Urge to urinate several times a night
_____Urge to urinate several times a day
TOTAL:_____
GRAND TOTAL:_____

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
TOTAL:_____

JOINTS/ MUSCLES
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness/limitation of movement
_____ Feeling of weakness of tiredness
_____ Pain or aches in the muscles
TOTAL:_____

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating
TOTAL:_____

ENERGY/ ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
TOTAL:_____

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Poor concentration
TOTAL:_____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
TOTAL:_____

Menstruating Women Only
____ Premenstrual Symptoms
_____ Cramping or pain during period
_____Absence of periods
_____Periods occur irregular
_____Prolonged/heavy flow during period

All Women
_____ Vaginal dryness
_____Sexual intercourse is uncomfortable
_____Breast tenderness/soreness
TOTAL:_____

Name:_____ Date:____/_____/_____

Previous Care for this Condition:

Have you seen another professional for THIS CONDITION other than a chiropractor? □ Yes □ No.

If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? □ Yes □ No

Explain: _____

***Previous Chiropractic Care:* □ I have not previously seen a chiropractor OR fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? □ Yes □ No. Why? _____

For how long? _____ Approximately how many visits?_____

***Current Medication (s):* List ANY/ALL medications you are CURRENTLY taking.**

Medication	Dosage	For What Condition?	How long have you been taking this?

***Current Vitamins, Herbs, etc:* List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.**

	Dosage	For What Condition, if any?	How long have you taken?

Surgery (ies): □ I deny having any surgical procedures. Write the DATE of the procedure in the blank following.

□ angioplasty_____	□ cosmetic_____	□ hysterectomy_____	□ pacemaker insertion_____
□ appendectomy_____	□ D & C_____	□ joint reconstruction_____	□ rotator cuff_____
□ caesarian section_____	□ dental surgery_____	□ joint replacement_____	□ spinal fusion_____
□ cardiac catheterization_____	□ gall bladder_____	□ knee repair_____	□ tonsillectomy_____
□ carpal tunnel repair_____	□ hemorrhoidectomy_____	□ laminectomy_____	□ other:_____
□ coronary artery bypass_____	□ hernia repair _____	□ mastectomy_____	□ other:_____

***Females ONLY: Ob/Gyn* Mark all that apply below.**

If you have been pregnant in the past, please fill in the appropriate information below.

_____Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____Number of C-sections	_____Number of vaginal deliveries
I… □ am currently pregnant	□ am NOT currently pregnant

Name:_____ Date:____/_____/_____

Injury (ies): **☐ I deny having any injuries.**
Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

☐ back injury_____ ☐ head injury (loss of consciousness)_____ ☐ motor vehicle accident_____
☐ broken bones_____ ☐ head injury (no loss of consciousness)_____ ☐ soft tissue injury _____
☐ disability (ies) _____ ☐ industrial accident_____ ☐ other:_____
☐ fall (severe)_____ ☐ joint injury_____ ☐ other:_____
☐ fracture _____ ☐ laceration (severe)_____ ☐ other:_____

Family History: **☐ I deny any family health problems.**

Health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that affect them? _____

Social History: **Mark all that apply below.**

1) Job Stress: ☐None ☐Moderate ☐Severe

Occupation/Job Title: _____ Work: _____ hrs/week

Description of Work:_____

Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs**)** ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)

2) Family Stress: ☐None ☐Moderate ☐Severe

3) Overall Sense of Wellbeing: ☐Pleased ☐Satisfactory ☐Displeased

4) How many hours on average do you sleep per night? _____

5) Alcohol: ☐ do not drink alcohol ☐ social consumption only ☐ drink regularly, quantity of ____glasses, per _____

6) Tobacco: ☐ Do not use tobacco ☐ Live with a smoker ☐ Quit smoking ☐ Smoke/ Chew _____ times a day.

7) Exercise: ☐ do not formally exercise ☐ walk occasionally ☐ exercise ____ days per week.

8) Diet: I eat fast food or pre-packaged meals _____ days per week. I eat home cooked, non prepackaged meals _____ per week.

9) How would you rate your current overall health and wellbeing on a 1-10 scale: _____. 1=disastrous and 10=great

10) Would you consider your current lifestyle (check one) ☐ healthy or ☐ unhealthy?

11) How much time have you lost from work or school in the past year due to illness or pain? ☐ 0-2 Days ☐ 3-14 days ☐ >15 days

Consent to treat:

I hereby state that the information provided by me is accurate and whole.
I hereby authorize the Doctor to treat my condition as he or she deems appropriate.

Patient Print Name: _____ Patient's Signature:_____ Date:_____

Guardian Name Print for Authorizing Care: _____

Guardian Signature of Authorizing Care: _____ Date: _____

Name:_____ Date:____/_____/_____

Consent for Treatment:

I, the undersigned, hereby authorize Dr. Bailey and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained. Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, partial or complete ligament or muscular tears, irritation or rupture of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Signature: _____

Authorization to Release Medical Information:

I authorize Dr. Bailey to release any medical information pertinent to my treatment plan or care for review to my insurance company and medical doctor. This authorization for release to my insurance company for information shall remain valid for the term of my coverage under my current policy.

Patient Signature: _____

Request for Payment of Benefits to Provider Care and Financial Responsibility:

I hereby authorize my insurance company to pay by check, and for it to be mailed directly to: Advanced Chiropractic at 35 Jackson Street Newnan, GA 30265, the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay in a current manner, any balance of said application charges. I agree that this office be given power of attorney to endorse/sign my name on any all drafts for payment of my bill. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Also any cost that this required for collection procedures will be added to your balance and will also become your responsibility. If you are filing Medicare, our office does not accept assignment, which means we file your claims to Medicare for you, you pay the balance due at the time of service and Medicare and your secondary or supplemental insurance will reimburse you.**

Patient Signature: _____

Consent for Treatment of Minor:

I hereby authorize Dr. Bailey and whomever he/she may designate as his/her assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship of child)_____ (child's name) _____.

Guardian's Signature: _____

X-Ray/Medical Records Release:

I have requested the release of (patients name) _____ which are a part of the records at (facility) _____ I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photo static copies, abstract or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. **Please forward this to Advanced Chiropractic at 35 Jackson Street Newnan, GA 30263.**

Patient Signature: _____

X-Ray/Medical Records Requests:

We reserve the right to charge a processing fee for x-rays and medical records as requested by the patient, other facility or attorney. This fee will be determined at the time of the request.

Patient Signature: _____