Advanced Chiropractic
2 Lee St. Ste C
Newnan, GA 30263
o. 770.253.5040
f. 678.854.7018

ADVANCED CHIROPRACTIC
Health & Wellness Center

New Patient Intake Forms

Personal Information

Name (First & Last): ____ Date: _______/________/_______

Date of Birth: _______/_______/_______ Sex (Circle one): Male / Female

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated Spouse's Name: _______________________

Address: ____ Apt: _____________

City: ________________________ State: ____________ Zip: ______________ Country: _____________________

Home Phone: (________)________-_________ Cell Phone: (________)________-_________ Provider: ____________

Email Address: ___________________________________

Our office has the capability to send you text or email reminders. Which would you prefer? (Circle one): Text Email

How did you hear about us? ☐Family/Friend/Co-Worker?: ____

☐Facebook ☐Instagram ☐Google ☐Drive by ☐Insurance ☐Other: _____________________________________

Emergency Contact

First Name: ____________________________________ Last Name: ______________________________________

Phone Number: (________)________-_________ Relationship: ☐Spouse ☐Relative ☐Friend ☐Other__________

Employment Information

Business Name: _______________________________ Occupation: _______________________________________

Address: _____________________________________ City:________________________ State:_____ Zip:_______

Social History

Job Stress: ☐None ☐Moderate ☐Severe

Job Description: ____

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

Family Stress: ☐None ☐Moderate ☐Severe

Overall Sense of Wellbeing: ☐Pleased ☐Satisfactory ☐Displeased

How many hours (on average) do you sleep per night? _________

Alcohol Consumption: ☐Never ☐Socially ☐Regularly, ______ glasses, per________

Tobacco Use: ☐Never ☐Quit smoking ☐Live with smoker ☐Smoke/chew ______ times a day

Exercise: ☐Do not formally exercise ☐Walk occasionally ☐Exercise ____ days per week

Diet: I eat fast food or pre-packaged meals ____ times per week. I eat home cooked, non prepackaged, meals ___ per week.

How would you rate your current overall health and wellbeing on a scale from 1 to 10? 1 = disastrous and 10 = great. ______

Would you consider your current lifestyle ☐healthy or ☐unhealthy?

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

Previous chiropractic care

Have you seen a chiropractor before? ☐Yes ☐No

If yes, please fill out 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? __________________

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Name: ___________________________________ Date______________

Adult Illnesses: Check all past conditions. Circle all CURRENT conditions

☐ADD	☐Cystic Kidney Disease	☐Hypertension	☐Psychiatric Problems
☐Alzheimer's	☐Depression	☐Influenzal Pneumonia	☐Scoliosis
☐Anemia	☐Diabetes (Insulin dep)	☐Liver Disease	☐Seizures
☐Arthritis	☐Diabetes (Non Insulin dep)	☐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 Attempts
☐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/AIDS	☐Psoriasis	

What is your chief complaint? (Why are you here? Please mention only one 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? ☐No ☐Yes When? ____

On a scale from 1 to 10, (1 being minimal and 10 being severe) how would you rate this symptom? ___________________

What percentage of the day do you experience this symptom? (1% being very rare & 100% being constant) _____________

Please list any additional complaints (in order of importance)

		(circle one)	(1-10)	(1%-100%)
1.__________________	When did it start? _____________	Gradual or Sudden?	Severity? _____	Percentage of the day? _____
2.__________________	When did it start? _____________	Gradual or Sudden?	Severity? _____	Percentage of the day? _____
3.__________________	When did it start? _____________	Gradual or Sudden?	Severity? _____	Percentage of the day? _____

Effects of current condition on daily activities or performance

Job Performance	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Bending	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Carrying	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Sitting to standing	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Climbing Stairs	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Driving	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Extended Computer Use	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Household Chores	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Lifting	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Concentration	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Self-Care	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Sleep	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Sitting	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Standing	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Walking	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Lying Down	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
Yard Work	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain

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Name: ________________________________ Date_____________

Effects of current condition on recreational activities and performance

________________	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain
________________	☐No Pain	☐Mild Pain	☐Moderate Pain	☐Severe Pain

Previous care for this condition

Have you seen another professional for this condition other than a chiropractor? ☐Yes ☐No

If yes, who? (Name): ____________________________________ Practice: ____________________________________

Type of treatment: ____

Were you satisfied with the results of your treatment? ☐Yes ☐No

Current medications (please list any/all medications you are *currently* taking)

Medication	Dosage	For what condition?	Length of time using

Current supplements (please list any/all non-prescription items you are *currently* taking)

Supplement	Dosage	For what condition?	Length of time using

Surgery (please right the date of the procedure in the blank)

☐I have not had any surgical procedures

☐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 (mark all that apply)

Number of complicated pregnancies: ______ Number of uncomplicated pregnancies: ______

Number of C-Sections: _____ Number of vaginal deliveries: _____

I am…. ☐ Currently pregnant ☐Currently *not* pregnant

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Health Insurance Portability & Accountability Act (HIPPAA) Consent Form

Release of Information: Your protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation for the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date which your revocation of consent is received will not be affected.

I, ____ (print) acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster, and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

Patient or Guardian Signature X____ Date: ___________________

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and include, but are not limited to, muscle spasms, aggravating and /or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, discolorations, and sprains.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep my appointments as recommended to me by treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my examination from any other doctor. I will notify the facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____________________________________ (print) have read the above consent and I have had an opportunity to ask questions regarding its consent. By signing below, I agree to the above-maned procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient or Guardian Signature: X____ Date: __________________

Financial Responsibility

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 is required for collection procedures will be added to my balance and will also become my responsibility. I understand, that if filing with Medicare, this office does not accept assignment. This means that claims will be filed to Medicare for you, and you will be responsible for the balance due at the time services are rendered. Medicare and your supplemental or secondary insurance will reimburse you.

Patient or Guardian Signature: X____ Date: _________________