

WELCOME

Chart #: _____

Patient Information

Name: _____
Last First MI

Mailing Address: _____

Phone# (H) _____ (M) _____ (E-Mail) _____

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Employer: _____ Phone: _____

May we call you at work? Yes No Can we leave a voicemail/message? Yes No

Emergency contact: Name: _____

Relation: _____ Phone: _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Date of Accident: ____/____/____ Has it been reported? Yes No If yes to whom? _____

Financial Information

Do you have health insurance? Yes No Name of Carrier: _____

Do you have Automobile Med-Pay insurance? Yes No Name of Carrier: _____

Name of the policy holder of the insurance: _____ SS#: _____

Relationship to patient (if other than self): _____ DOB: _____ Phone: _____

ID # _____ Group # _____ Phone number _____

We can not file your insurance if this section is left uncompleted and the bill will be sent to you.

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment, Consent of Care and Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THIS PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. Lab tests maybe filed directly by laboratory. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

HIPAA

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X) _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Name: _____ Chart #: _____

HEALTH HISTORY

Who is your primary care physician (doctor and/or practice)? _____

Please check to indicate if you are currently experiencing any of the following conditions:

- Neck Pain/Stiffness
- Back Pain/Stiffness
- Arm/Hand Pain
- Leg/Knee Pain
- Headaches
- Dizziness
- Asthma
- Pins/Needles in Arms
- Pins/Needles in Legs
- Fatigue
- Sleeping Difficulties
- Loss of Smell
- Allergies
- Blurred Vision
- Light Bothers Eyes
- Depression
- Nervousness
- Tension
- Cold Sweats
- Stomach Problems
- Night Pain
- Sudden Weight Loss
- Loss of Taste
- Loss of Memory
- Jaw Problems
- Constipation
- Shortness of Breath
- Bowel/Bladder Changes
- Nausea
- Cold Feet
- Chest Pain
- Fever
- Fainting

Please check to indicate if you have ever had any of the following:

- Aids/HIV
- Alcoholism
- Allergy Shots
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorder
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Fractures
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herniated Disc
- Herpes
- High Cholesterol
- Kidney Disease
- Liver Disease
- Measles
- Migraines
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Osteoporosis
- Pacemaker
- Parkinson's Disease
- Pinched Nerve
- Pneumonia
- Polio
- Prostate Problems
- Prosthesis
- Psychiatric Care
- Rheumatoid Arthritis
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Other _____
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Tumors/Growths
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease
- Whooping Cough

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- Heart Disease _____
- Cancer _____
- Diabetes _____
- Arthritis _____
- Other _____

Do you exercise? Frequently Moderately Occasionally None

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following?

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

PATIENT/PARENT GUARDIAN INITIALS: _____

Name: _____ Chart # _____

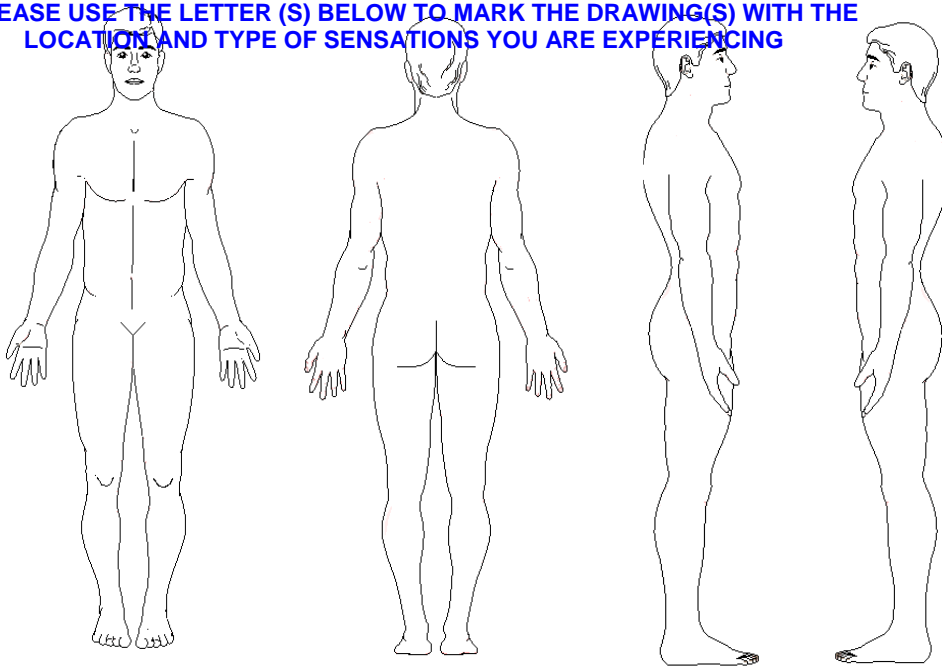
CURRENT SYMPTOM (S)

Reason for visit _____

*** PLEASE USE THE LETTER (S) BELOW TO MARK THE DRAWING(S) WITH THE LOCATION AND TYPE OF SENSATIONS YOU ARE EXPERIENCING**

KEY:

- T = Tight**
- D = Dull**
- A = Ache**
- S = Sharp**
- N = Numb**
- B = Burning**
- ST = Stiff**
- TG = Tingling**
- SH = Shooting**
- TH = Throbbing**
- O = Other**



*** PLEASE INDICATE THE SEVERITY OF YOUR CONDITION ON A SCALE OF 0-10**

(0 being no pain, 10 being the worst possible pain) 1. _____ currently 2. _____ at it's worst

When did you first notice the symptoms? _____

Did anything cause the pain/symptoms? _____

Is the pain: Constant OR intermittent (Come and Go)

Is it getting progressively worse? No Yes

Type of Pain? Tight Stiff Ache Sharp Shooting

Throbbing Burning Dull Numb Tingling Other

Does anything make it worse? _____

Does anything make it better? _____

Does it radiate? No Yes Right Arm Left Arm Right Leg Left Leg

Do you experience the pain at a particular time of day? _____

Do you experience night pain? No Yes, explain _____

Does it interfere with your: Work Sleep Daily Routine Recreational Activities

What activities do you enjoy, but do poorly, or not all because of the pain? _____

Painful movements: Sitting Standing Walking Bending Lying Down

What have you done to treat the pain before today? _____

PATIENT/PARENT GUARDIAN INITIALS: _____

Name _____ Chart # _____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please notify the Doctor:

- | | | |
|--|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do our legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Do you suffer from headaches, dizziness or memory loss?
Comment: _____ | NO | YES |
| 12. Do you have difficulty maintaining your balance?
Comment: _____ | NO | YES |
| 13. Do you suffer from vertigo or blurred vision?
Comment: _____ | NO | YES |
| 14. Do you suffer from a reduced hearing capacity or ringing in the ears?
Comment: _____ | NO | YES |
| 15. Do you have bladder or bowel control problems on a regular basis?
Comment: _____ | NO | YES |
| 16. Do you difficulty sleeping, lifting objects or interacting with others since your injuries ?
Comment: _____ | NO | YES |

PATIENT/PARENT GUARDIAN INITIALS: _____

MEDICAL RECORDS REQUEST

DATE: _____

Please list the name of the physician(s) who referred you to us or any physician, person(s), business(s) you would allow us to request or release your personal Health information.

To: _____ (primary care physician)
_____ (significant other)
_____ (attorney/case manager)
_____ (other care takers)

I, _____ hereby request that my recent medical records be released to:

_____ Physician of _____ practice.

236 Johnson Ferry Road, NE

Sandy Springs, Georgia 30328

Phone: 404-255-0666

Fax: 404-705-9942

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at anytime. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____