3542 Sixes Road
Suite 100
Canton, GA 30114
770-720-1388
www.gcgsixes.com

Patient Information

Date:

Full Name: Nick Name:

Street Address:

City: State: Zip:

Home Phone: Cell Phone: Cell Phone Carrier:

Work Phone: Email:

Preferred method of contact: □ Email □ Text

Date of Birth: Age: Gender: □ Male □ Female Social Security #

Occupation: Employer:

Marital Status □ Single □ Married □ Divorced □ Widowed Spouses Name:

Number of Children: Ages:

Who is responsible for your bill? □ Self □ Spouse □ Health Insurance □ Auto Insurance □ Medicare

Health Insurance Company: Policy #

Primary's Name: Date of Birth: SS#

Emergency Contact: Emergency Contact Phone:

Payment in full is expected at time of service unless prior arrangements have been made

Briefly describe what brings you to the office? ____________________

List any prior treatment received for your problems (medication, surgery, therapy)

Have you had Chiropractic care in the past? □ Yes □ No

If so, where? ____________________

Were you pleased with your care? □ Yes □ No

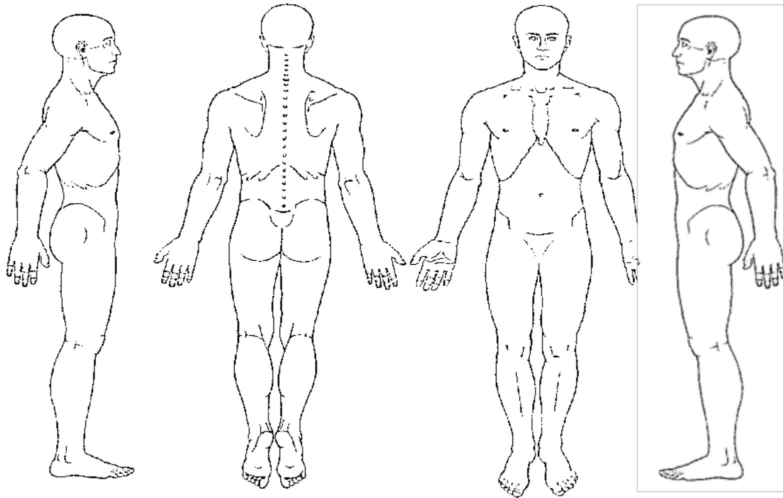
How did you hear about us?

I understand and agree to the following:

- A history, consultation, examination and x-rays are conducted for diagnostic and informational purposes and I am requesting these services.
- It is my responsibility to complete the clinic's forms accurately.
- It is my responsibility to notify the doctor/office staff if any of my information has changed or requires updating.
- Original x-rays are the clinic's property. Film(s) and report(s) will be released to me upon written request.

Patient/Guardian Signature: ______________________________ Date: __________________

Please mark the areas of all your complaints on the diagrams to the right. Include any descriptors or comments concerning your health complaints that are not mentioned above



List your primary complaint: ____

How long have you been experiencing this primary complaint? _______________________________

How does the primary complaint feel? □ dull/achy □ sharp □ numb □ tingling □ burning □ cold

How often do you experience the primary complaint? □ constantly □ daily □ weekly □ monthly □ yearly

What do you believe is causing your primary complaint? ____

What services interest you?

□ Injury Prevention
□ Spinal and Body Alignment
□ Range of Motion, Mobility or Flexibility
□ Balance and Coordination Training
□ Patient Education Classes
□ Strengthening and Stamina Exercise
□ Treatment for Pain
□ Body Composition Counseling
□ Nutritional & Supplement

Using the scale below, rate how your primary complaint affects your life (mark only one box)

1) No pain or discomfort	2) Slight discomfort	3) Pain that does <u>not</u> affect my activity	4) Pain that affects my daily activities	5) Pain that prevents performing my daily activities	6) Pain that limits my work schedule	7) Pain that prevents working at all	8) Pain that prevents working <u>and</u> all personal activity	9) Pain that keeps me bed ridden	10) Pain that causes thoughts of suicide
□	□	□	□	□	□	□	□	□	□

List any auto collisions you have been involved with either as a driver or a passenger.

Type of collision	Type of treatment received	Date of collision

List any sports injuries that you have experienced. Begin with the most recent.

Type of Injury	Type of treatment received	Date of Injury

Have you ever had back surgery? □ Yes □ No

Health Questionnaire

Patient Name: Date:

When did this episode begin?

What happened?

Has this condition existed in the past?

□ Yes □ No □ Yes, but has been dormant

□ Comes & goes □ Symptoms ongoing

How frequent do your symptoms occur?

□ Infrequent □ Occasional

□ Frequent □ Constant

How are your daily activities affected?

□ Doesn't affect □ Somewhat affects

□ Seriously affects □ Prevents activities

Check the quality of your symptoms

(check all that apply)

□ dull □ sharp □ aching

□ burning □ numbing □ tingling

□ spasm □ stinging □ shooting

□ stiff □ pounding □ constricting

Is this condition getting progressively worse?

□ Yes □ No □ Constant □ Comes & goes

What relieves your pain?

□ standing □ sitting □ heat □ ice □ stretching

□ exercise □ bed rest □ nothing

□ other ___________________________

What aggravates your pain?

□ standing □ reaching □ sitting □ stairs

□ sneezing □ coughing □ lifting

□ bending □ neck movement

□ other ___________________________

Does your pain/symptoms radiate to your:

□ head □ face □ shoulders □ arms

□ hands □ fingers □ buttocks □ hip

□ rear thigh □ front thigh □ calf □ shin

□ ankle □ foot □ toes

On a scale of 0-10 (10 = the worst) how bad does it get when it's at its worst? ____________

Is this condition interfering with your:

□ work □ sleep □daily routine

□ family life □ hobbies □sexual function

□ social life □ other_________________

How long has it been since you felt good?

□ weeks □ months □ years □ other ___________

Sleep

Do you have trouble falling asleep? □ Yes □ No

Do you awaken in middle of the night? □ Yes □ No

Do you awaken earlier than normal? □ Yes □ No

Do you feel well rested? □ Yes □ No

Other Health Care Providers you have tried:

□ Family MD □ Neurologist □ Physical therapist

□ Massage □ Gynecologist □ Orthopedic surgeon

□ Counselor □ Proctologist □ Gastroenterologist

□ Psychiatrist □ Psychologist □ Ear, nose & throat

□ Hypnotist □ Acupuncturist □ Endocrinologist

□ Allergist □ Heart Specialist □ Pulmonary specialist

□ Internist □ Chiropractor □ Rheumatologist

□ Nutritionist □ Kidney specialist □ Pain specialist/clinic

□ Other ______________________________________

Check off any Tests you have received:

□ X-Rays □ MRI □ CAT scan

□ EKG □ Allergy Test □ Nerve conduction test

□ EMG □ Bone Scan □ Bone density test

□ Myelogram □ Ultrasound □ Other_____________

Check off any Treatments you have tried:

□ OTC drugs □ Ice □ Prescription drugs

□ Massage □ Cortisone shots □ Electrical stimulation

□ Heat □ Ultrasound □ Physical therapy

□ Ointments □ Surgery □ Acupuncture

□ Traction □ Manipulation □ Other____________

Work History

Do your present complaints affect the number of hours you work per day? □ Yes □ No

Are you working beyond your physical limitations because you *have* to work? □ Yes □ No

Job involves: □ Lifting □ Bending □ Stooping

□ Twisting □ Turning □ Carrying □ Walking

□ Sitting □ Other __________________________

Has this caused you to miss work: □ Yes □ No

If so, how much? __________ Last day work?_______

If **RETIRED**, what occupation did you retire from?

If **DISABLED**, what is your disability and how long have you been disabled?

If **DISABLED**, what was your last employed function?

Patient Name: ______________________

Check any MEDICATIONS you are taking, including Over-the-Counter (OTC) & Prescription (Rx)

(check all that apply)	OTC	Rx	(check all that apply)	OTC	Rx	(check all that apply)	OTC	Rx
Headaches	□	□	Diabetes	□	□	Bowels/Laxative	□	□
Pain	□	□	Water Pills	□	□	Hormones	□	□
Muscle Relaxants	□	□	Heart/Cardiovascular	□	□	Thyroid	□	□
Arthritis	□	□	Blood Pressure	□	□	Antibiotics	□	□
Steroids	□	□	Cholesterol	□	□	Birth Control	□	□
Sinus/Allergy	□	□	Ulcers	□	□	Heartburn/Stomach	□	□
Asthma/Bronchitis	□	□	Depression/Anxiety	□	□	Other	□	□
Sleeping	□	□	Psychological	□	□	NOT TAKING Medications	□	□

Do you have any difficulties with any of the following ACTIVITIES? (check all that apply)

□ Bathing	□ Drying Hair	□ Brushing Teeth	□ Put on shoes	□ Preparing meals	□ Put trash out
□ Showering	□ Combing Hair	□ Making Bed	□ Tying shoes	□ Eating	□ Laundry
□ Washing Hair	□ Washing Face	□ Putting on shirt	□ Put on pants	□ Washing dishes	□ Going to toilet
□ Standing	□ Walking	□ Kneeling	□ Bending back	□ Twisting left	□ Leaning left
□ Sitting	□ Stooping	□ Reaching	□ Bending	□ Twisting right	□ Leaning right
□ Reclining	□ Squatting	□ Bending forward	□ Bending rig	□ Leaning forward	□ Leaning back
□ Prolong Standing	□ Prolong sitting	□ Prolonged walk	□ Prolong kneel	□ Climbing inclines	□ Driving car
□ Carry objects	□ Lift from floor	□ Pushing	□ Exercise upper	□ Climbing stairs	□ Using keyboard
□ Carry briefcase	□ Lift from table	□ Pulling	□ Exercise lower	□ Exercise arms	□ Exercise legs
□ Bowling	□ Jogging	□ Swimming	□ Ice skating	□ Comp Sports	□ Dating
□ Golfing	□ Dancing	□ Skiing	□ Roll skating	□ Hobbies	□ Dining out

REVIEW OF SYSTEMS (check all that apply)

General
□ Chills
□ Fainting
□ Fever
□ Forgetfulness
□ Loss of Weight
□ Nervousness
□ Sweats

Genito-Urinary
□ Blood in urine
□ Frequent urination
□ Lack of bladder
□ Painful urination

Eyes
□ Crossed eyes
□ Double vision
□ Vision - Flashes
□ Vision - Halos
□ Blurred vision

Ears/Nose/Throat
□ Earache
□ Ear Discharge
□ Loss of hearing
□ Nose bleeds
□ Hoarseness
□ Difficulty swallowing
□ Persistent cough

Respiratory
□ Cough
□ Congestion
□ Distress
□ Sputum
□ Shortness of breath

Endocrine
□ Weight gain
□ Weight loss
□ Hoarseness
□ Heat intolerance
□ Cold intolerance
□ Breast changes
□ Hair changes
□ Extreme Thirst

Gastrointestinal
□ Poor Appetite
□ Bloating
□ Bowel changes
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Nausea
□ Rectal bleeding
□ Stomach pain
□ Vomiting no blood
□ Vomiting with blood

Cardiovascular
□ Poor circulation
□ Rapid heat beat
□ Swelling of ankles
□ Varicose Veins

Men Only
□ Breast lumps
□ Erection difficulties
□ Lump in testicles
□ Penis discharge
□ Sore on penis
□ Prostrate problem
□ Other___________

Women Only
□ Abnormal pap smear
□ Bleeding between periods
□ Breast lumps
□ Miscarriage
□ Extreme menstrual pain
□ Hot flashes
□ Nipple discharge
□ Vaginal discharge
□ Vaginal infections
□ Painful intercourse
□ Date of last menstrual period________________
□ Date of last pap smear _____________________
□ Have you had a mammogram?_________
□ Are you pregnant?______
□ Number of children_____
□ Other ________________

Integumentary (skin)
□ Bruise easy
□ Hives
□ Change in moles
□ Sores that won't heal
□ Itching
□ Sores/ulcers
□ Rash
□ Scars

Neurological
□ Seizures
□ Vertigo
□ Dizziness
□ Hand Trembling
□ Loss of sensations
□ Loss of facial expression
□ Weak grip
□ Paralysis
□ Difficulty of speech
□ Tingling
□ Numbness
□ Un-coordination

Psychiatric
□ Hyperventilation
□ Insecurity
□ Trouble sleeping
□ Irritable
□ Un-decidedness
□ Timid
□ Hallucinations
□ Loss of memory
□ Alcoholism
□ Drug Addiction
□ Drug dependency
□ Extreme worry
□ Sexual problems
□ Suicidal thoughts

Conditions
□ AIDS
□ Anorexia
□ Allergies
□ Arteriosclerosis
□ Appendicitis
□ Bleeding disorders
□ Breast lumps
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□ Chemical dependency
□ Chicken pox
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heart disease
□ Hepatitis
□ Hernia
□ Herpes
□ High cholesterol
□ HIV positive
□ Kidney disease
□ Liver disease
□ Malaria
□ Measles
□ Migraine headaches
□ Mononucleosis
□ Multiple sclerosis
□ Mumps
□ Pneumonia
□ Polio
□ Psychiatric care
□ Rheumatic fever
□ Scarlet fever
□ STD
□ Stroke
□Tuberculosis
□ Typhoid fever
□ Ulcers
□ Venereal disease
□ Other ____________

Name: Date:

Personal Health History

Family Doctor Name

Address City State Zip

Date of last visit How long have you been under their care?

Please identify your past health history including accidents, injuries and treatments

Surgery

☐ Appendectomy
☐ Bypass
☐ Cancer
☐ Cosmetic
☐ Elective
____
☐ Eye
☐ Hysterectomy
☐ Pacemaker
☐ Spine
☐ Tonsillectomy
☐ Vasectomy
☐ Other ___________________

Treatments

Check ones received in the past and now

Past	Now	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth control pills
☐	☐	Blood transfusion
☐	☐	Chemotherapy
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone replacement
☐	☐	Inhaler
☐	☐	Massage therapy
☐	☐	Physical therapy

Injuries: Have you ever….

☐ Had a fracture or broken bone
☐ Had a spinal nerve disorder
☐ Been knocked unconscious
☐ Been injured in an accident
☐ Used a crutch/other support
☐ Used neck or back bracing
☐ Received a tattoo
☐ Had body piercing
☐ Other ___________________________________
____
____

Social History

Do you exercise? ☐ Yes ☐ No How often? ________day(s) per week; Other: _______________________________________

What activities? ☐ Walking ☐ Running ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Swimming ☐ Other ____________________

Do you smoke? ☐ Yes ☐ No How much? _______________ How often______________ For how long?_____________

Do you drink alcohol? ☐ Yes ☐ No How much? _______________ How often______________ For how long? _____________

Do you drink coffee? ☐ Yes ☐ No How much? _______________ How often______________ For how long? _____________

Do you use artificial sweeteners? ☐ Yes ☐ No

Do you eat organic foods? ☐ Yes ☐ No Do have high stress ☐ Yes ☐ No

Do you take vitamins? ☐ Yes ☐ No Please list: ____

Do you drink bottle water? ☐ Yes ☐ No How much per day? __________________

Family Health History

☐ AIDS
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Cancer
Other: ___________________________
☐ Bone fracture
☐ Cirrhosis
☐ Diabetes
☐ Dislocated joints
☐ Multiple Sclerosis
☐ Heart Problems
☐ HIV/ARC
☐ High Blood Pressure
☐ Kidney Trouble
☐ Spinal Disc Disease
☐ Ulcer
☐ Low Blood Pressure
☐ Mental Difficulties
☐ Prostrate Trouble
☐ Rheumatic Fever
☐ STDS's
☐ Polio
☐ Sinus trouble
☐ Epilepsy
☐ Thyroid trouble
☐ Tuberculosis
☐ Addiction
☐ Scoliosis

If history of Cancer, Type: ☐ Breast ☐ Lung ☐ Other _____________ Relationship__________________________

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Authorizations and Releases

Patient Name:____Social Security#____________________________

Consent for Treatment

I, the undersigned, hereby authorize the doctor and his staff named below 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. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. 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 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 UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient Signature:____ Date________________________

Authorization to Release Medical Information

I authorize the doctor and his/her staff named below to release any information deemed appropriate ate concerning my physical condition and treatment to any insurance company or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and herby release him/her of any consequences thereof. I also agree that all insurance information given to this clinic is correct and complete. I agree that a photo static copy shall serve as the original.

Patient Signature:____ Date________________________

Authorization to Pay the Doctor/Clinic-Insurance

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to this doctor/clinic named below as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given the power of attorney to endorse/sign my name on any and all drafts for payment of my bill. I agree that a photo static copy shall serve as the original.

Patient Signature: ____ Date________________________

Authorization to Pay the Doctor/Clinic-Attorney

I, the undersigned patient am directing my attorney to pay any outstanding bills out of my settlement and, in effect, protection any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's protection and consideration of his awaiting payment. I further under stand that such payment is not contingent on any settlement, judgment or verdict by which I any eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.

Patient Signature:____ Date________________________

Consent for Treatment of a Minor

I (we) being the parent, guardian or custodian of___________________________, a minor. The age of ____________, do hereby authorize, request and direct, the doctor and his staff named below and whomever he/she may designate as his/her assistant(s) to perform in his/her judgment any necessary examination, X-ray and chiropractic treatment as is necessary.

Parent/Guardian Signature:____

Authorization to Pay/Release Authorization is granted to:

Georgia Chiropractic Group at Sixes
3542 Sixes Road, Suite 100
Canton, GA 30114
770-720-1388

NOTICE OF INFORMATION PRACTICES

3542 Sixes Road
Suite 100
Canton, GA 30114
770-720-1388
www.gcgsixes.com

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.
You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical re cords for treatment.

You may inspect and receive copies of your records within 30 days a request to do so is received. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny the request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Patient Signature:_______________________________

The effective date of this Notice of Information Practices is_____________________________

Thank you.