

WELCOME

1 one

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: (____) _____

Work Phone #: (____) _____ Ext: _____

Cell Phone #: (____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

3 three

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

2 two

INSURANCE INFO

Primary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: (____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: (____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

4 four

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (____) _____

Work Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____

PLEASE CONTINUE ON BACK

Reason for today's visit: Emergency New injury Old injury Chronic pain Wellness
 Are you in pain: Yes No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
 Did your injury occur during: Work Sports/play Auto Accident Routine/Household activity
 When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
 Please explain what happened: _____
 Is your condition getting worse? Yes No Constant Comes and goes.
 Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

Has this or something similar happened in the past?
 Yes No Explain: _____

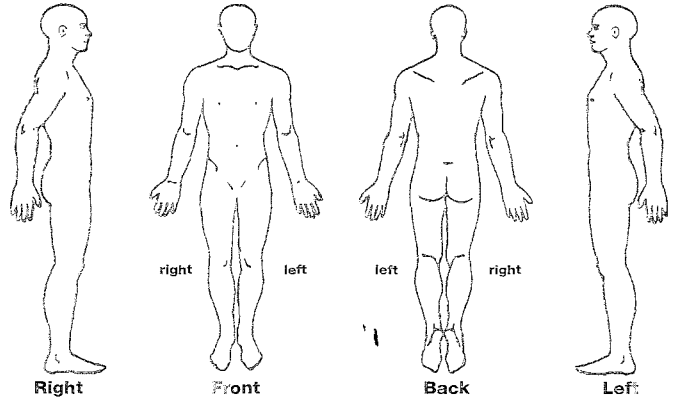
Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? Yes No If so, where? _____

Have you ever been treated by a Chiropractor? Yes No

Clinic or Dr's name: _____

Clinic phone#: _____



Are you taking any of the following medications? Nerve pills Pain killers(including aspirin) Muscle relaxers

Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|-----------------------------|--------------------------------|-------------------------|--------------------------------------|---------------------------|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N HIV+ / AIDS / ARC |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Anemia / Diabetes |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Severe / Frequent Headaches | Y N Kidney Problems |
| Y N Ulcers / Colitis | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Emphysema / Asthma | Y N Tuberculosis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/Joints/Implants | Y N Arthritis |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes How much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since: ___/___/___

For woman: Are you taking Birth Control? Yes No

Are you Nursing? Yes No Are you Pregnant? No Yes If so, how many weeks? _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___

Adult Patient Parent or Guardian Spouse

UPDATE
(OFFICE USE)

Initials _____ Date ___/___/___

Comments _____

Initials _____ Date ___/___/___

Comments _____

Initials _____ Date ___/___/___

Comments _____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

**Hamilton Mill Family Chiropractic
3509 Braselton Highway Building F
Dacula, GA 30019**

CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

All patients in the State Of Georgia are required to approve of all services rendered by their doctor before any services are performed. Refusal to comply with Georgia Law releases your doctor of all liabilities and his/her right to refuse treatment.

I, _____, hereby request and give consent to my doctor to perform all necessary chiropractic examinations, adjustments, therapy, rehabilitation, and medical diagnostic x-rays. I understand that my doctor will consult with me before any procedures are performed, at which time, I will give him permission to perform all necessary procedures to treat my condition.

I understand that during my treatment that care may be rendered by other doctors at Hamilton Mill Family Chiropractic. I understand that I will be made aware of any such circumstances before being treated.

I understand that I have any opportunity to discuss with the doctor and/or with the office manager, the nature and purpose of my chiropractic care before any treatment is rendered.

Patient Signature _____ Date: _____

X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please Choose One:

_____ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities.

Signature: _____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant _____yes _____no _____ don't know

I could be pregnant _____yes _____no _____ don't know

My menstrual period is late _____yes _____no _____ don't know

I have an IUD _____yes _____no

I have had a tubal ligation _____yes _____no

I have had a hysterectomy _____yes _____no

I have irregular menstrual periods _____yes _____no

My last menstrual period began _____

I have begun menopause _____yes _____no

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ Date: _____

STRESS SURVEY

Location of Lecture: _____

Name _____ Age _____ Phone (Home) _____ (Work) _____

Address _____ City _____ State _____ Zip _____

Occupation _____ # Hours per week currently working _____

Spouse Occupation _____ # Hours per week currently working _____

Check off any of the following symptoms you have experienced in the past 6 months:

- | | | | |
|------------------------------------------------|---------------------------------------------------|---------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Headaches/ Migraines | <input type="checkbox"/> Insomnia/ Sleep Problems | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Weight Problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Irritability | <input type="checkbox"/> Asthma | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Pain/Tension/Numbness | <input type="checkbox"/> Digestive Trouble | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Arms |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Hands |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Gas | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Bloating | | |

Which of the above bothers you the most? _____

How long have you been bothered by the condition? _____

Describe how it feels or affects you when it is at its worst. _____

Does this cause you to be:

- Moody
- Irritable
- Interrupt Sleep
- Restricted on Daily Activities

Does this affect your work?

- Decision Making
- Poor Attitude
- Decreased Productivity
- Exhausted at End of Day
- Unable to Work Long Hrs.

Does this affect your life?

- Lose Patience with Spouse or Children
- Restricted Outside Duties
- Hinders Ability to Exercise or Participate in Sports
- Interferes with Ability to Participate in Hobbies or Desired Activities

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If you could eliminate one of the above that would it be? _____

There are several alternatives available to you. Please check the most appropriate for you.

I would like to come to the Doctor's office for a complete evaluation. There is **NO CHARGE** for this examination. This will allow me to find out if I can be helped by Chiropractic without any financial barriers

I would like the Doctor to call me to discuss my health problems before making an appointment.