PORTER FAMILY CHIROPRACTIC CENTER

2655 Dallas Hwy. Suite 110
Marietta, GA 30064
(770)427-1889

Name: _____ Date: _____
First Middle Last

Address: _____ City: _____ State & Zip: _____

Date of Birth: _____/_____/_____ Male / Female Social Security #: _____-____-_____

Circle: Married Single Widowed Divorced Partner Partner/Spouse's Name: _____

Home #: ( ) _____ Work #: ( ) _____

May we contact you at work? YES NO Cell / Pager #: ( ) _____

Email address: _____ @ _____ ._____ (for official office use only)

Occupation: _____ Employer's Name: _____

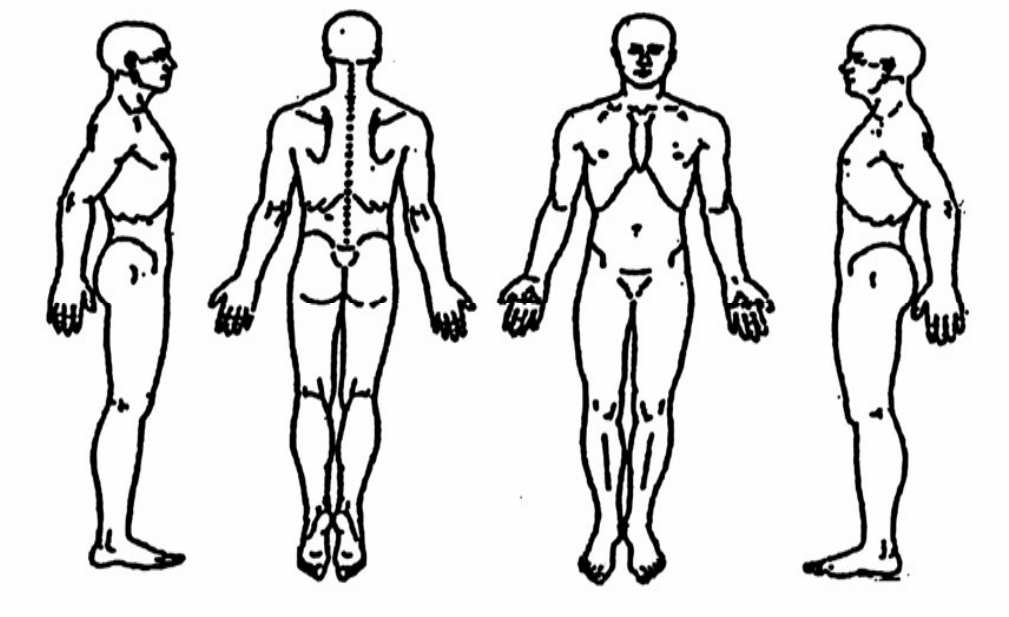
Address: _____ City / State / Zip: _____

Non Family Emergency Contact: _____/_____(____)_____
Name Relationship Phone

Who referred you to us? _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other _____

2. Indicate on the drawings below ALL areas of concern and # in order of priority!!



3. How often do you experience your symptoms?

Area #1
□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

Area #2
□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

Area #3
□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

Area #1
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

Area #2
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

Area #3
□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

Area #1
□ Getting Worse
□ Not Changing
□ Getting Better

Area #2
□ Getting Worse
□ Not Changing
□ Getting Better

Area #3
□ Getting Worse
□ Not Changing
□ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Area #1 _____ Area #2 _____ Area #3 _____

7. How much has the problem interfered with your work?

Area #1
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

Area #2
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

Area #3
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

8. How much has the problem interfered with your active daily living?

Area #1
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

Area#2
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

Area #3
□ Not at all □ A little bit
□ Moderately □ Quite a bit
□ Extremely

9. How long have you had this problem? Area #1_____ Area #2_____ Area #3_____

10. How do you think your problem began?

Area #1_____

Area #2_____

Area #3_____

12. What aggravates your problem?

Area #1 _____

Area #2 _____

Area #3 _____

13. What makes your problem feel better?

Area #1_____

Area #2_____

Area #3_____

14. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

15. What concerns you the most about your problem (Please Pick Only One)?

□ Could be Serious □ Not Going Away □ Getting Worse □ Affecting Work □ Affecting Sleep
□ Affecting Mental Outlook □ Affecting Relationships □ Affecting Leisure □ Other: _____

16. What is your: Height_____ Weight _____

17. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

18. What type of exercise do you do? _____

19. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

21. For each of the conditions below, place a check in the "present" column for your current concerns. If you have had any of the conditions in the last 6 months, then place a check in the "past" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

22. List any prescription medications or over-the-counter medications you are currently taking:

_____

_____

23. List any nutritional supplements you are currently taking:

_____

_____

24. List all surgical procedures you have had:

_____

_____

25. What activities does your job require?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Drives:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Walk**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Other:**	□ Manual Labor	□ Reads a lot	□Travels a lot

26. What activities do you do outside of work? _____

27. Have you ever been hospitalized? □ No □ Yes

If yes, why_____

28. Have you seen a chiropractor before? □ No □ Yes

If yes, who: _____how long ago: _____ results were: □ Good □ Mixed □ Bad

29. Have you had significant physical trauma in the past? □ No □ Yes

If yes, please explain (include type of trauma and year):_____

_____

_____

30. Anything else pertinent to your visit today? _____

I authorize this office to release any information requested by my insurance company or other health care individuals to document my claim for benefits or assist in further health care purposes. The above information was completed correctly to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes in my health status or financial status.

Patient (or Guardian) Signature_____ **Date** _____

Consent to evaluate and adjust a minor child

I,_____ , being the parent or legal guardian of
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature *Date*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____

_____ _____

Signature *Date*

Consent for Treatment

I, the undersigned, herby authorize the Doctors of Porter Family Chiropractic and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that 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 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.**

Patient's Signature_____ Date____/____/____ Witness_____

HIPPA INFORMATION

DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to Porter Family Chiropractic use my address, phone number and clinical records to contact me with birthday cards, newsletters, patient letters, thank-you cards, first adjustment calls, testimonials and information about treatment alternatives or other health related information.
2. By signing this form you are giving Porter Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Porter Family Chiropractic. The written notice must contain the following information:

Your Name, Social Security Number and Date of Birth; A Clear Statement of Your Intent to Revoke This AUTHORIZATION; The Date of Your Request and Your Signature.

I have read and agree to the financial policy and Hippa privacy policy set above. Furthermore should I for any reason, discontinue care, I understand that the entire balance for professional services rendered to date will be due within 30 days. I agree that you may release my information to my insurance agent / adjuster or their agents regarding my care in this office. I also understand that the records including x-rays are a permanent record and are the property of Porter Family Chiropractic. Copies are available at a nominal charge. A copy of this agreement will serve as the original. This AUTHORIZATION is requested by Porter Family Chiropractic for its own use or disclosure of PHI. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Porter Family Chiropractic will not refuse to provide treatment.

_____ _____

Name (printed) Date

_____ _____

Signature of Patient / Guardian Witness

Your Family and Your Health are in Great Hands!

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

RE:

Patient: _____

Employer: _____

Claim/Group #: _____

SS# / ID#: _____

I hereby instruct the _____ Insurance Company
To pay by check, made out and mailed directly to:

PORTER FAMILY CHIROPRACTIC CENTER
2655 Dallas Hwy. Suite 110

Marietta, GA 30064

Or

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it to the following:

C/O PORTER FAMILY CHIROPRACTIC CENTER

2655 Dallas Hwy. Suite 110
Marietta, GA 30064

the professional or medical expense benefits allowable, and other wise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at PORTER FAMILY CHIROPRACTIC CENTER this _____ day of _____ 20_____

_____ _____
Signature of Policyholder Witness

Signature of claimant, if other than Policyholder

Porter Family Chiropractic Center
OFFICE POLICIES AND PROCEDURES

Please check next to each item and sign/date the back of this sheet.

_____ **1. Chiropractic Results:** We are very result-focused, however there are many factors which effect how quickly your body responds to our care. Some are: your age, occupation, how long you've had your vertebral subluxations (pinched nerves), and the number of subluxations present in your spine. Your body has the incredible ability to heal itself from within! The Doctor will consider these factors before making a recommended treatment plan. Our goal is to get you to a level of health where Wellness Care becomes the desired result-- adding Years to your Life, and Life to your Years!

_____ **2. Symptoms:** It is important to understand the differences between your symptoms and their causes. A symptom is an outward pain/discomfort created by your body to communicate that something is wrong on the inside. The cause of the pain/symptom may be a result of something that happened long ago, never surfacing until now. As your spine is corrected you will have good and bad days. Don't get caught up in this roller coaster; just know that it is ***normal.*** You will get the best results if you understand that this is a process that takes time designed to get you functioning at your peak level and on the road to wellness. Stay focused on the outcome and enjoy the journey towards a healthier you!

_____ **3. Appointments:** The next two appointments after today are about giving you as much information about you and your condition and will be of upmost importance. The first, the doctor will present the findings as to the cause of your problems, and the next will be to give you more information on how the body is designed to work, called the New Patient Orientation. Your adjustments will not be scheduled at specific times, however you will be scheduled to be here on specific days of the week. A certain number of adjustments in a given time period is necessary to get you the best results from re-training your nerve and muscle memory. Maintaining your Doctor-recommended treatment plan will offer you the best opportunity to heal and build wellness, preventing regression in your expected results. While we can't predict the exact number of adjustments you will need, we do know that ***consistency creates the best results***.

_____ **4. Daily Visit Procedure:** When you arrive please sign in and take a seat in the reception room until the Front Desk Chiropractic Assistant directs you to an adjusting room. When in the room, close the door, ***lie down on your stomach and relax*** to aid in the success and comfort of your adjustments. Once the Doctor learns your spine your adjustments will be focused and last only a few minutes. When leaving the room, please **leave the door OPEN for the next patient to enter**.

Patient: _____ Date: _____

PORTER FAMILY CHIROPRACTIC CENTER

Our *ultimate goal* for you is to help your entire body and its organs to perform at their highest level possible helping you to attain and then maintain maximum *health*. In order for us to further evaluate your areas of malfunctioning health conditions, please circle the answers to all the questions below. Please indicate if the problem pertains to you, your spouse, or another family member (mom, dad, child).

Name _____ Date _____

Occupation _____ Age _____

	You	Spouse	Family	Parent (M/F)
1. Have you ever had any problems with your Heart? High or Low Blood Pressure, High or Low Pulse Rate, Placquing of Arteries, Pains in Chest, Heart Attack(s), or other. _____	_____	_____	_____	_____
2. Have you ever had any problems with your Lungs? Difficulty in Breathing, Asthma, Shortness of Breath, Bronchitis, Pneumonia or Other. _____	_____	_____	_____	_____
3. Have you ever had any problems with your Stomach? Indigestion, Heartburn, Upset stomach, Ulcers, Hiatal Hernia, Reflux, or Other. _____	_____	_____	_____	_____
4. Have you ever had any problems with your Digestive System? Constipation, Diarrhea, Gas, Bloating, Irritable Bowel Syndrome, or Other. _____	_____	_____	_____	_____
5. Have you ever had any problems in your Reproductive System? Women: PMS, Irregular Cycles, Menopause Infertility, Cysts of Ovaries or Uterus Precancerous Conditions, or Other. _____	_____	_____	_____	_____
Men: Prostate Enlargement, Difficulty in Starting Urination, Infertility, or Other. _____	_____	_____	_____	_____
6. Do you "Catch" Bugs/Viruses Easily (colds, flu, etc.)?	_____	_____	_____	_____

7. Have you ever had any problems with your Ears?

Earaches, Ear Infections, Tubes in Ears or Scheduled

Surgery for Tubes, Ringing in Ears, or Other. _____

_____ _____ _____ _____ _____

8. Have you ever had any problems with?

Headaches, Migraines, Sinus Problems, Nose problems,

Eye problems, Allergies, Sleep problems or Other. _____ _____ _____ _____ _____

You Spouse Family Parent (M/F)

9. Have you ever had any problems with your Kidneys/Bladder/Liver
Difficulty or pain upon urination, Leaky Bladder, Blood

Disorder(s), Kidney stones, Gallstones, Bladder infections,

or Other. _____ _____ _____ _____ _____

10. Have you ever had any problems with your Pancreas?
High or Low Blood Sugar, Taking Insulin or other

Medications, or Other. _____ _____ _____ _____ _____

11. Have you ever had any problems with Hormonal Imbalances?
Anxiety, Depression, Change of Life Hormonal problems,

Thyroid problems, ADD/ADHD or Other._____ _____ _____ _____
_____

12. Do you regularly take aspirin or other over the counter drugs? _____ _____ _____ _____

13. Have you ever smoked? _____ _____ _____ _____
Do you smoke more than 10 cigarettes a day? _____ _____ _____ _____

14. Have you ever been diagnosed with any of the following: cancer, fibromyalgia, chronic fatigue, multiple sclerosis, lupus or other, give details.

_____

_____

15. Do you have any other health problems or pain not mentioned above? Please describe where and how long you have experienced the problem(s).

_____

_____

16. When you were born, were you delivered natural; vaginal with anesthesia, forceps, or vacuum extraction; or by c-section? _____

17. On a scale of 1-10, (1 being least important, and 10 being the most important) Describe the priority of your health. Your answer is: _____

18. Choose one of the following which best describes your health goal(s).

_____ Only interested in getting out of pain.

_____ To take my health beyond the absence of pain, and to regain my health even though it may take more time and effort.

_____ Once I attain my best health possible, I am interested in maintaining my new wellness state for as long as possible during my lifetime.

19. I understand that my body is the ONLY one I'll ever have, therefore it makes sense to want to make it the "BEST" possible. Yes No

20. I also understand that this is the ONLY *LIFE* I will ever enjoy, therefore I want to Learn as much as possible on how I can take care of it during the years to come.

Yes No

21. Does it make sense to you that when you improve your health, it will in turn improve the QUALITY **OF YOUR *LIFE?* Yes No**