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: _____

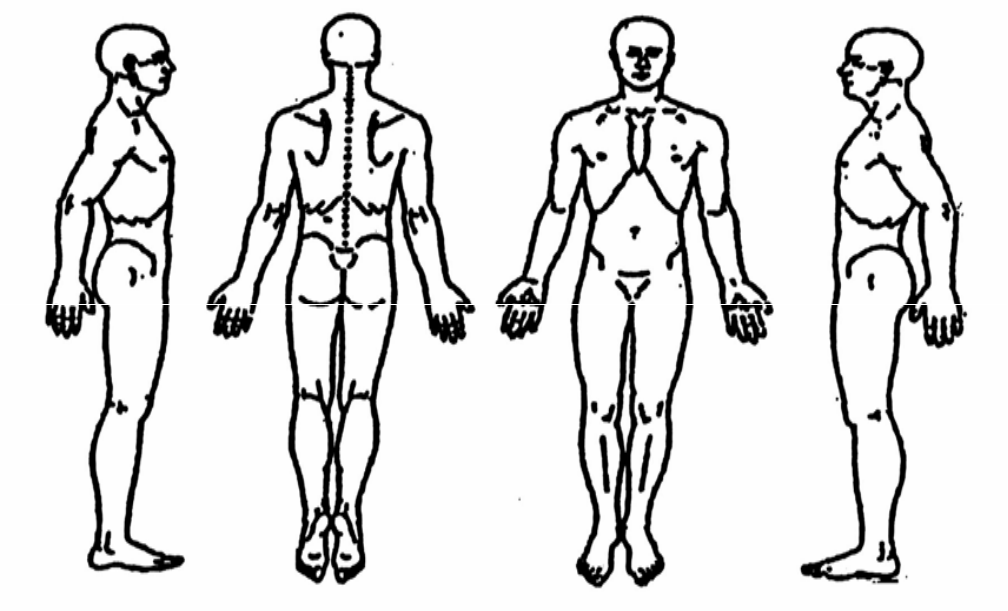
Address: _____ City / State / Zip: _____

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 listed below, place a check in the "past" column if you have had the condition in the last 6 months but are not currently experiencing. If you presently have a condition listed below, place a check in the "present" 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!