Today's Date: _____

234 River Park North Dr.
Woodstock GA 30188
678-909-5993

Name: _____ Date of Birth:_____ Age:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email:_____

Marital Status:

□ Married Spouse's Name:_____
□ Single
□ Divorced
□ Widowed

Number of Children:_____

How did you hear about us?

□ Friend who is a patient _____
□ Google
□ Facebook
□ Instagram
□ Other:_____

Your Employer:_____ Occupation:_____

Who is responsible for your bill? □ Self □ Spouse □ Parent

1. **Reason for Chiropractic Care**:_____

2. **Is your condition**: □ the result of an accident or injury? □ Work □Auto □Other_____
□ a worsening long term problem?

3. **Onset**: When did you first notice your symptoms?

_____

4. **Intensity**: How extreme are your symptoms?

1 5 10
□ - □ - □ - □ - □ - □ - □ - □ - □ - □
Absent Painful Agonizing

5. **Duration/Timing**: When and how often do you feel it? □ Constant □ Sometimes

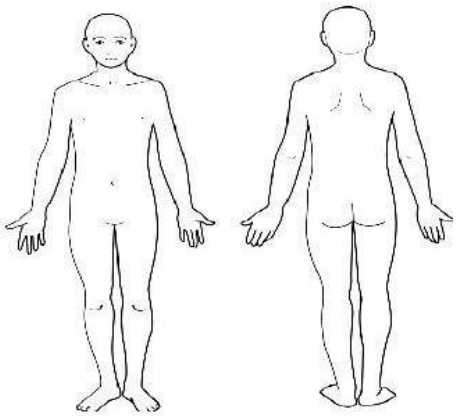
Worse in the: □ Morning □ Evening

Better in the: □ Morning □ Evening

6. **Quality of Symptoms**: What does it feel like?

□ Numbness
□ Tingling
□ Stiffness
□ Dull
□ Aching
□ Cramping
□ Nagging
□ Sharp
□ Burning
□ Shooting
□ Throbbing
□ Stabbing
□ Other _____

7. **Location**: Where does it hurt?
X = current condition O= Past condition



8. **Radiating**: To what area does the pain radiate, shoot, or travel?

_____

9. **Aggravating/Relieving Factors**: What makes it worse (i.e. time of day, movement, or certain activities)?

What worsens the problem?

_____

What lessens the problem?

_____

10. **Prior Interventions**: What have you done to relieve the symptoms?

□ Medication □ Surgery □ Ice/Heat □ Acupuncture
□ Homeopathic Remedies □ Chiropractic □ Physical Therapy □ Massage
□ Stretching/Exercise □ Other _____

11. **What else should the doctor know about your condition**?

_____

12. **How does your current condition interfere with your**:

Work or career:_____

Recreational activities:_____

Household Chores:_____

Personal Interactions: _____

13. **Review of Systems**: Chiropractic care focuses on the integrity of your nervous system which controls and regulates you entire body. Please check beside any condition that you have NOW or had in the PAST.

Musculoskeletal

Now	Past	
□	□	Osteoporosis
□	□	Arthritis
□	□	Scoliosis
□	□	Neck Pain
□	□	Back Problems
□	□	Hip Disorders
□	□	Knee Injuries
□	□	Leg Pain
□	□	Poor Posture
□	□	Arm Pain
□	□	TMJ
□	□	Shoulder Pain

Endocrine

Now	Past	
□	□	Thyroid Issues
□	□	Immune Disorders
□	□	Hypoglycemia
□	□	Frequent Infection
□	□	Swollen Glands
□	□	Low Energy

Neurological

Now	Past	
□	□	Anxiety
□	□	Depression
□	□	Headache
□	□	Dizziness
□	□	Pins/Needles
□	□	Numbness

Digestive

Now	Past	
□	□	Anorexia/Bulimia
□	□	Ulcer
□	□	Food Sensitivities
□	□	Heartburn
□	□	Constipation or Diarrhea
□	□	Ulcerative Colitis

Genitourinary

Now	Past	
□	□	Kidney Stones
□	□	Infertility
□	□	Kidney Dysfunction
□	□	Prostate Problems
□	□	Erectile Dysfunction
□	□	PMS Symptoms

Cardiovascular

Now	Past	
□	□	High Blood Pressure
□	□	Low Blood Pressure
□	□	High Cholesterol
□	□	Poor Circulation
□	□	Angina
□	□	Excessive Burning

Sensory

Now	Past	
□	□	Blurred Vision
□	□	Ringing in the ears
□	□	Hearing Loss
□	□	Chronic Ear Infections
□	□	Loss of Smell
□	□	Loss of Taste

Constitutional

Now	Past	
□	□	Fainting
□	□	Low Libido
□	□	Poor Appetite
□	□	Fatigue
□	□	Sudden Weight Change
□	□	Weakness

Respiratory

Now	Past	
□	□	Asthma
□	□	Apnea
□	□	Emphysema
□	□	Hay Fever
□	□	Shortness of Breath
□	□	Pneumonia

Integumentary

Now	Past	
□	□	Skin Cancer
□	□	Psoriasis
□	□	Eczema
□	□	Acne
□	□	Hair Loss
□	□	Rash

Past, Personal, Family, and Social History

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

14. **Illnesses**

Now	Past		Now	Past		Now	Past		Now	Past		Now	Past		Now	Past	
□	□	Aids	□	□	Alcoholism	□	□	Allergies	□	□	Arteriosclerosis	□	□	Cancer	□	□	Diabetes
□	□	Epilepsy	□	□	Heart Disease	□	□	Hepatitis	□	□	Multiple Sclerosis	□	□	Mumps/Polio	□	□	STD
□	□	Stroke	□	□	Ulcer	□	□	Other:_____									

15. **Surgery**

Now	Past		Now	Past		Now	Past		Now	Past		Now	Past	
□	□	Appendectomy	□	□	Bypass Surgery	□	□	Cancer	□	□	Cosmetic Surgery	□	□	Elective Surgery:_____
□	□	Eye Surgery	□	□	Hysterectomy	□	□	Pacemaker	□	□	Spine	□	□	Tonsillectomy
□	□	Other: _____												

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16. **Treatments**

Check the ones you are receiving now or have in the past received.

Now	Past	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth Control Pills
☐	☐	Blood Transfusions
☐	☐	Chemotherapy
☐	☐	Chiropractic Care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone Replacement
☐	☐	Inhaler
☐	☐	Massage Therapy
☐	☐	Physical Therapy
☐	☐	Nutritional Supplements

_____

☐ ☐ Medications (list)

_____

_____

_____

17. **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 or other support

☐ Used neck or back bracing

18. **Family History**

Please give the history of your immediate family members

Relative	State of Health Good	Poor	Illnesses
Mother	☐	☐	_____
Father	☐	☐	_____
Sister	☐	☐	_____
Brother	☐	☐	_____

19. **Are there any other hereditary health issues that you know about?**_____

20. **Lifestyle History**

Alcohol Use ☐ Daily ☐ Weekly How much? _____

Coffee Use ☐ Daily ☐ Weekly How much? _____

Tobacco Use ☐ Daily ☐ Weekly How much? _____

Exercise ☐ Daily ☐ Weekly Type: _____

Water ☐ Daily ☐ Weekly How much? _____

Vitamins ☐ Daily ☐ Weekly Type _____

Females: Is it possible that you are pregnant? ☐ Yes ☐ No

21. What is the primary stressor in your life? _____

22. In what position do you sleep most often? _____

23. What would be the most significant thing you could do to improve your health? _____

24. Do you have any specific health goals? _____

25. How much sleep do you get per night?_____

26. Do you drink a half gallon of water daily? Y N

27. **Activities of Daily Living**

How does your condition interfere with your ability to function?

	No Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐
Rising out of chair	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Lying down	☐	☐	☐
Bending over	☐	☐	☐
Climbing stairs	☐	☐	☐
Using a computer	☐	☐	☐
Getting in/out of a car	☐	☐	☐
Driving	☐	☐	☐
Looking over shoulder	☐	☐	☐
Caring for family	☐	☐	☐

	No Effect	Moderate Effect	Severe Effect
Grocery Shopping	☐	☐	☐
Household chores	☐	☐	☐
Lifting Objects	☐	☐	☐
Reaching overhead	☐	☐	☐
Showering/Bathing self	☐	☐	☐
Getting to sleep	☐	☐	☐
Staying asleep	☐	☐	☐
Concentrating	☐	☐	☐
Exercising	☐	☐	☐
Yard work	☐	☐	☐
Endurance	☐	☐	☐

IGNITE CHIROPRACTIC

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation complex. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express maximum health potential.

Patient Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities of physical therapies, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and or other licensed Doctor of Chiropractic who now or in the future work at the clinicor office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/ or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, included but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/ her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Healthcare Authorization and Privacy Policy

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Ignite Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Ignite Chiropractic to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If Ignite Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering or voice mail.
- I give permission to Ignite Chiropractic to use my testimonial written by me for marketing purposes, such as sharing with other patients or potential patients, in their brochures, on their website, or in ads in print media.
- I give Ignite Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some on my protected health information during the course of care. Should I need to speak with my doctor at any time in private the doctor will provide a room for these conversations.
- By signing this form, I am giving Ignite Chiropractic permission to use and disclose my protected health information in accordance with the directives listed above.

The use of this format is intended to make my experience with Ignite Chiropractic office more efficient and productive, as well as, to enhance my access to quality health care and health information. This authorization will remain in effectfor the duration of my care at Ignite Chiropractic, plus 7 years or until revoked by me.

AUTHORIZATION AND ASSIGNMENT—AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his/ her staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/ her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

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 acted in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official at Ignite Chiropractic. The written notice must contain the following information: Your name, Social Security Number, a date of birth, a clearstatement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Ignite Chiropractic for its own use/disclosure of PHI. (*Minimum necessarystandards apply*)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Ignite Chiropractic will not refuse to provide treatment however, I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Ignite Chiropractic and Massage will be unable to contact me 3) all contact with Ignite Chiropractic regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form, the Right to Revoke Authorization Form, and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with this practice

Ignite Chiropractic: Austin P. Saxon, D.C

Social Security Number: XXX-XX-_____	Date of Birth:
Patient Name: (please print)	
Patient's signature (or parent or guardian):	Date:
Name of personal representative (if applicable)	
Description of representative's authority to act on patient's behalf:	
Representative's Signature:	Date: