Intelligent Chiropractic

Confidential Patient Information

(IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST)

PATIENT INFORMATION Today's Date: _____

Name: _____
(last name) (first name) (mi)

Nickname _____ Date of Birth: _____

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone: **(H)**_____ **(W)** _____ **(C)**___ _____

Social Security #: _____ Age: _____ ❑ Male ❑ Female

Name of Spouse/Nearest Relative: _____Phone: _____

Your Occupation_____ Your Employer: _____

How did you hear of our office? _____

If someone referred you, please indicate name: _____

May we use your name in thanking this person? YES_____ NO_____

Intelligent Chiropractic

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate your symptoms (1-10, with 1 being least serious)

	Description	Quality of Pain/Radiating	Rating
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

SYMPTOMS DEVELOPED FROM: ❑ AUTO ACCIDENT ❑ JOB RELATED INJURY ❑INJURY ❑ACCIDENT ❑ILLNESS ❑ GRADUAL ONSET ❑ UNKNOWN CAUSE

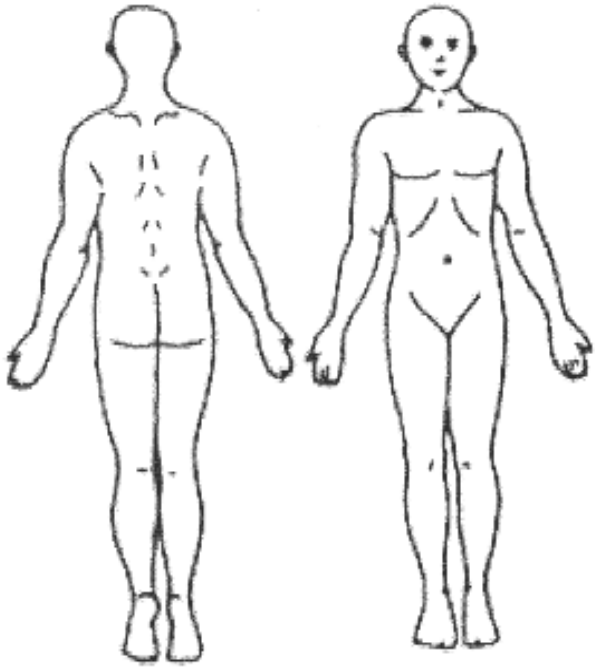
DATE OCCURRED:_____

SYMPTOMS PERSISTED FOR ____HOUR(S) ___DAY(S) ___WEEK(S) ___MONTH(S)__YEAR(S)

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

Key: A=Ache B=Burning N=Numbness
P= Pins & Needles S=Stabbing



Intelligent Chiropractic

SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT ❑ARE NEARLY CONSTANT

SYMPTOMS ARE WORSE IN: ❑MORNING ❑AFTERNOON ❑EVENING ❑CONSISTENT ❑UNCHANGED

ARE YOU PREGNANT ❑NO ❑YES PERCENT OF YOUR DAY SPENT SITTING _____%

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

ARE YOU TAKING ANY MEDICATIONS ❑YES ❑NO WHAT KIND?

_____

_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT <u>AGGRAVATE</u> YOUR CONDITION:

❑BENDING	❑COUGHING	❑DRIVING	❑EXERCISING
❑GETTING UP AND DOWN	❑INCREASED ACTIVITY	❑LIFTING	❑LYING DOWN
❑OVERHEAD ACTIVITIES	❑PREPARING FOOD	❑REACHING	❑SITTING
❑SNEEZING	❑STANDING	❑STRAINING AT STOOL	
❑TURNING HEAD	❑WALKING		

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT <u>RELIEVE</u> YOUR CONDITION:

❑BENDING	❑HEAT	❑ICE	❑LIFTING
❑LYING DOWN	❑MEDICATION	❑REACHING	❑RESTING
❑SITTING	❑STANDING	❑STRETCHING	
❑TURNING HEAD	❑WALKING		

PLEASE CHECK ANY <u>ADDITIONAL SYMPTOMS</u> YOU MAY BE EXPERIENCING:

❑blurred vision	❑buzzing in ears	❑cold feet	❑cold hands
❑cold sweats	❑concentration loss	❑constipation	❑depression/weeping spells
❑diarrhea	❑dizziness	❑face flushed	❑fainting
❑fatigue	❑fever	❑head seems too heavy	❑headaches
❑insomnia	❑light bothers eyes	❑loss of balance	❑loss of smell
❑loss of taste	❑low resistance to colds	❑muscle jerking	❑NONE
❑numbness in fingers	❑numbness in toes	❑pins and needles in arms	❑pins and needles in legs
❑ringing in ears	❑shortness of breath	❑stiff neck	❑stomach upset

Intelligent Chiropractic

MEDICAL/FAMILY HISTORY

(S = Self M = Mother F = Father)

(Please indicate which **PAST** conditions have been experienced **PRIOR** to present complaint by marking appropriate boxes)

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	nervous
❑	❑	❑	allergies	❑	❑	❑	epilepsy	❑	❑	❑	NONE stated
❑	❑	❑	anemia	❑	❑	❑	fibromyalgia	❑	❑	❑	numbness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	osteoporosis
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	hepatitis	❑	❑	❑	reproductive disorder
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	high cholesterol	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	HIV/ARC	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	is deceased	❑	❑	❑	scoliosis
❑	❑	❑	constipation	❑	❑	❑	kidney disorder	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	bowel control loss	❑	❑	❑	sinus troubles
❑	❑	❑	deceased	❑	❑	❑	lung disease	❑	❑	❑	stroke
❑	❑	❑	depression	❑	❑	❑	menstrual cramps	❑	❑	❑	thyroid problems
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	diarrhea	❑	❑	❑	muscular dystrophy	❑	❑	❑	ulcers
❑	❑	❑	indigestion	❑	❑	❑	neck pain	❑	❑	❑	STD

Date of Last Physical Exam_____
Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

If yes, describe Condition _____
Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

SURGICAL HISTORY:

1. _____ _Date: _____
2. _____ Date:_____
3. _____ Date:_____

ACCIDENT HISTORY :

❑Job ❑Auto ❑Other 1. _____ Date: _____

❑Job ❑Auto ❑Other 2._____Date:_____

❑Job ❑Auto ❑Other 3._____Date:_____

Intelligent Chiropractic
Assignment and Instruction For Direct payment to my Doctor

Patient name: _____

Date of accident or onset: _____

Claim or Group #: _____

I hereby instruct and direct my insurance company to pay by check make out and mailed directly to:

Intelligent Chiropractic LLC
5871 Glenridge Dr. Suite 115
Atlanta, Georgia 30328

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

Intelligent Chiropractic LLC
5871 Glenridge Dr. Suite 115
Atlanta, Georgia 30328

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

_____ _____

Signature of policyholder or claimant *Date*

Intelligent Chiropractic
Consent to Treat

When a patient seeks chiropractic health care and we adept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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 its maximum health potential.

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

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(PRINT NAME)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
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.

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 x-ray can be hazardous to an unborn child. Date of last menstrual period _____.

_____ _____
Signature Date

Intelligent Chiropractic
Consent to Treat

My signature acknowledges receipt of the services and gives my consent to receive treatment. I further authorize the above named doctor or clinic any and all benefits due as a result of treatment provided. I am aware that I am personally responsible for charges and / or balances not covered by my insurance carrier. I hereby state and agree that a photocopy of this statement will be deemed as valid and binding on all parties involved as the original copy.

Attention Medicare Patients: In accordance with Medicare Act, Section 1862(a)(1) this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(a)(1) of the Medicare Act. If Medicare determines that a particular service, although normally covered, is not reasonable and necessary under Medicare program standards, Medicare will deny payment for the services rendered. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient Name: _____

Patient Signature: _____

Date signed: _____

Intelligent Chiropractic
Policies

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.

3. Method of payment you plan to use to take care of today's charges?

   ☐ Cash ☐ Check ☐ Credit (all major cards accepted)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore I understand Intelligent Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Intelligent Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Intelligent Chiropractic to obtain a credit report if deemed necessary.

We require a minimum of 24 hours advance notice to cancel an appointment. By not canceling in advance, you are denying other health care. We reserve the right to charge the full fee of $25.00 for all missed appointment not cancelled with 24 hours notice. Insurance companies will not reimburse for missed visits, therefore, this will be your sole responsibility.

_____ _____

Patient Signature *Date*

_____ _____

Guardian Signature Authorizing Care *Date*

Intelligent Chiropractic
Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (Please Print) *Date*

_____

Parent or Authorized Representative (if applicable)

_____

Signature