

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 _____

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PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

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

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

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

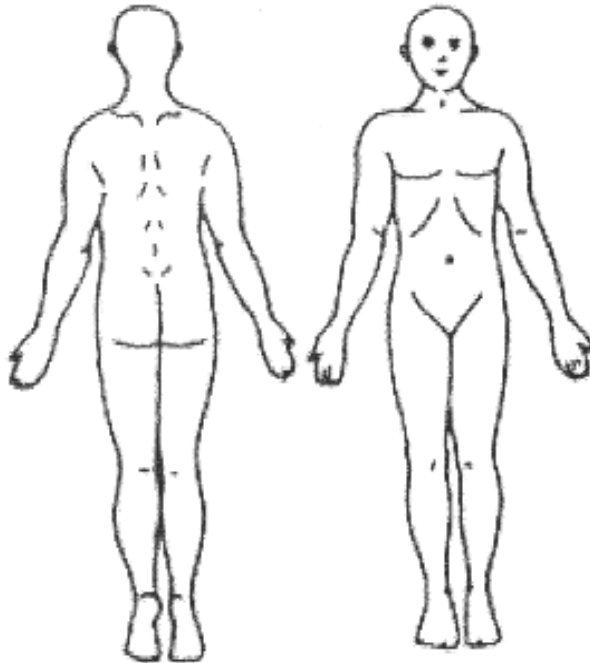
DATE OCCURRED: _____

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



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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 AGGRAVATE YOUR CONDITION:

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> COUGHING | <input type="checkbox"/> DRIVING | <input type="checkbox"/> EXERCISING |
| <input type="checkbox"/> GETTING UP AND DOWN | <input type="checkbox"/> INCREASED ACTIVITY | <input type="checkbox"/> LIFTING | <input type="checkbox"/> LYING DOWN |
| <input type="checkbox"/> OVERHEAD ACTIVITIES | <input type="checkbox"/> PREPARING FOOD | <input type="checkbox"/> REACHING | <input type="checkbox"/> SITTING |
| <input type="checkbox"/> SNEEZING | <input type="checkbox"/> STANDING | <input type="checkbox"/> STRAINING AT STOOL | |
| <input type="checkbox"/> TURNING HEAD | <input type="checkbox"/> WALKING | | |

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- | | | | |
|---------------------------------------|-------------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> HEAT | <input type="checkbox"/> ICE | <input type="checkbox"/> LIFTING |
| <input type="checkbox"/> LYING DOWN | <input type="checkbox"/> MEDICATION | <input type="checkbox"/> REACHING | <input type="checkbox"/> RESTING |
| <input type="checkbox"/> SITTING | <input type="checkbox"/> STANDING | <input type="checkbox"/> STRETCHING | |
| <input type="checkbox"/> TURNING HEAD | <input type="checkbox"/> WALKING | | |

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

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

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

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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 accept 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