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**Personal Information:**

Today's Date \_\_\_/\_\_\_/\_\_\_ Patient \_\_\_\_\_

Address \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Nickname \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Marital Status \_\_\_\_\_ Gender:  M  F

Social Security No. \_\_\_\_\_ Driver's License No. \_\_\_\_\_ State \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Family Medical Doctor \_\_\_\_\_ May we contact Dr.?  Yes  No

Name of Spouse \_\_\_\_\_ Name of parent(if minor) \_\_\_\_\_

Spouse or parent employed by \_\_\_\_\_ Phone \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Were you referred to our office for one of the following programs? If so please indicate which one:

- Chiropractic       Low Level Laser Therapy       Massage       Orthopedic Aid

**Financial/Insurance Information:**

Responsible party \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Social Security No. \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

I have submitted my insurance card to the office receptionist.

Insurance Company Address \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Medicare No. \_\_\_\_\_

**Emergency:**

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_

**Accurate Disclosure & Consent To Treat:**

I certify that the above information is accurate and complete to the best of my knowledge. I will not hold the staff at Georgia Chiropractic responsible for any errors of omissions that may have been made in the completion of this form. If I am entitled to insurance benefits, I assign all benefits payable to Georgia Chiropractic. I also acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to pursue collections, or legal actions for any amount, I agree to pay for all costs and expenses, including, but not limited to attorney fees. I hereby authorize the clinical staff at Georgia Chiropractic to administer treatment as the doctor deems necessary.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_



Patient Name \_\_\_\_\_

Using the adjacent charts, circle all affected areas:

When did your symptoms start? \_\_\_\_\_

Describe how they began: \_\_\_\_\_

\_\_\_\_\_

How often do you experience your symptoms?

- Constantly
- Frequently
- Occasionally
- Intermittently

Do you have pain at night? \_\_\_ Yes \_\_\_ No

Are your symptoms changing? \_\_\_ Yes \_\_\_ No

How are your symptoms changing? \_\_\_ getting better \_\_\_ not changing \_\_\_ getting worse

Describe the nature of your symptoms?

- |                                     |                                   |
|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp      | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Dull Ache  | <input type="checkbox"/> Burning  |
| <input type="checkbox"/> Numb       | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Unbearable | <input type="checkbox"/> None     |

Rate your pain with the following scale:

(no pain) 1    2    3    4    5    6    7    8    9            10 (unbearable)

Is your condition interfering with: \_\_\_ work \_\_\_ sleep \_\_\_ daily routine

If you selected one of the above, please explain \_\_\_\_\_

Please list the 3 hardest things for you to perform due to your symptoms: (E.g., driving)

\_\_\_\_\_

Is there anything you can do to relieve the symptoms? \_\_\_ Yes \_\_\_ No

If "Yes" describe:

What makes the problem worse? \_\_\_ standing \_\_\_ sitting \_\_\_ lying \_\_\_ bending \_\_\_ lifting \_\_\_ twisting (L/R)

Other:

Who have you seen for this problem and what did they do?

Medications taken:

Was it beneficial? \_\_\_ Yes \_\_\_ No Explain \_\_\_\_\_

\_\_\_\_\_

If female, are you pregnant? Yes/No How far along are you? \_\_\_\_\_

Who is your OB/GYN? \_\_\_\_\_ Phone \_\_\_\_\_

Patient Signature \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_



Patient Name \_\_\_\_\_

Indicate if you have had any of the following conditions:  
For each of the conditions below, place a check in the PAST column if you have had the condition in the past, or check the PRESENT column if you currently have the condition.

Past / Present

**Musculoskeletal**

<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	Mid-back pain
<input type="checkbox"/>	<input type="checkbox"/>	Low-back pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain
<input type="checkbox"/>	<input type="checkbox"/>	Upper arm/elbow pain
<input type="checkbox"/>	<input type="checkbox"/>	Wrist/hand pain
<input type="checkbox"/>	<input type="checkbox"/>	Hip/upper leg pain
<input type="checkbox"/>	<input type="checkbox"/>	Knee/lower leg pain
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/foot pain
<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain
<input type="checkbox"/>	<input type="checkbox"/>	Joint swelling
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis

Past / Present

**Cardio-Pulmonary**

<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/heart attack
<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Anuerysm
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/COPD
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinusitis

Past / Present

**Nervous System**

<input type="checkbox"/>	<input type="checkbox"/>	General fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Visual problems
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ear noises)

Past / Present

**Gastrointestinal**

<input type="checkbox"/>	<input type="checkbox"/>	Weight changes
<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	Poor/excessive appetite
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	<input type="checkbox"/>	Liver disorder
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Excessive gas/bloating
<input type="checkbox"/>	<input type="checkbox"/>	Chron's/Cholitis
<input type="checkbox"/>	<input type="checkbox"/>	Black/bloody stool
<input type="checkbox"/>	<input type="checkbox"/>	Irritable colon
<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type ____)
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat/swallowing

Past / Present

**Pathology**

<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Past / Present

**Female or Male**

<input type="checkbox"/>	<input type="checkbox"/>	Irregular menstrual flow
<input type="checkbox"/>	<input type="checkbox"/>	Breast disease/lumps
<input type="checkbox"/>	<input type="checkbox"/>	Hormone replacement
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Prostatitis
<input type="checkbox"/>	<input type="checkbox"/>	Prostrate cancer
<input type="checkbox"/>	<input type="checkbox"/>	Mammogram

Past / Present

**General**

<input type="checkbox"/>	<input type="checkbox"/>	Metal implants
<input type="checkbox"/>	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	<input type="checkbox"/>	Drug/alcohol dependence
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Depression

Indicate if an immediate family member has had any of the following hereditary problems ( **please list who**):

Rheumatoid Disease   
  Cancer   
  Heart Disease   
  Diabetes   
  Lupus   
  High Cholesterol  
 High Blood Pressure   
 Other (Please specify \_\_\_\_\_)

List all perscriptions, over-the-counter medications and/or nutritional supplements that you are currently taking:

\_\_\_\_\_

List all surgical procedures and hospitalizations you have had. Please include date:

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_