

# Chiropractic Center of Marietta

PT# \_\_\_\_\_

## PATIENT INFORMATION

DATE OF FIRST APPOINTMENT \_\_\_\_\_

LAST NAME: _____	FIRST NAME: _____	M.I.: _____
SSN: _____	DATE OF BIRTH: ____/____/____	AGE: _____
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
HOME PHONE NUMBER: (____) _____	CELL NUMBER: (____) _____	
STREET ADDRESS: _____		
CITY: _____	STATE: _____	ZIP CODE: _____
EMAIL: _____		

YOUR EMPLOYER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

WORK PHONE NUMBER: \_\_\_\_\_ OCCUPATION \_\_\_\_\_

<b>IF WE ARE FILING INSURANCE FOR YOU, PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK <u>OR</u> FILL IN THE FOLLOWING:</b>	
INSURANCE COMPANY: _____	
POLICY NUMBER: _____	PHONE: _____
<b>IF YOUR INJURY WAS A RESULT OF AN AUTO ACCIDENT PLEASE PROVIDE US WITH THE FOLLOWING:</b>	
ATTORNEY: _____	CLAIM NUMBER: _____

WHO REFERRED YOU? \_\_\_\_\_

# Chiropractic Center of Marietta

PT# \_\_\_\_\_

**DESCRIBE COMPLAINT #1:** \_\_\_\_\_

**IT CAME ON:**  GRADUALLY  IMMEDIATELY | **IT IS GETTING:**  BETTER  SAME  WORSE

**GRADE:** 0----1----2----3----4----5----6----7----8----9----10

0= no discomfort | 10 = extreme discomfort  
**INTENSITY:**  MINIMAL  SLIGHT  MODERATE  SEVERE | **FREQUENCY:**  INTERMITTENT  OCCASSIONAL  FREQUENT  CONSTANT

**DESCRIBE THE FEELING:**  DULL  SHARP  ACHING  SHOOTING  SPASM  THROBBING  BURNING  
 NUMB  TINGLING  OTHER

**LOCATION OF PAIN:**  RIGHT  LEFT  FRONT  BACK  OTHER: \_\_\_\_\_

**ACTIONS THAT AFFECT THIS PAIN: (B) BRINGS PAIN ON (A) AGRAVATES THE PAIN (R) RELIEVES THE PAIN**

IN THE MORNING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	IN THE AFTERNOON: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	BENDING FORWARD: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
BENDING BACK: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	BENDING LEFT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	BENDING RIGHT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
TWISTING RIGHT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	TWISTING LEFT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	COUGHING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
SNEEZING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	STRAINING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	STANDING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
LIFTING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	SITTING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	HEAT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
COLD: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	REST: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	LYING DOWN: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
MEDICATIONS: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R		

OTHER 1: \_\_\_\_\_  B  A  R

**PAIN RADIATES TO:**

HEAD:  RIGHT  LEFT | NECK:  RIGHT  LEFT | SHOULDER:  RIGHT  LEFT  
 ARM:  RIGHT  LEFT | HAND:  RIGHT  LEFT | HIP:  RIGHT  LEFT  
 LEG:  RIGHT  LEFT | FOOT:  RIGHT  LEFT

PAIN ALSO RADIATES TO: \_\_\_\_\_

**ADDITIONAL COMMENTS:** \_\_\_\_\_

**DESCRIBE COMPLAINT #2:** \_\_\_\_\_

**IT CAME ON:**  GRADUALLY  IMMEDIATELY | **IT IS GETTING:**  BETTER  SAME  WORSE

**GRADE:** 0----1----2----3----4----5----6----7----8----9----10

0= no discomfort | 10 = extreme discomfort  
**INTENSITY:**  MINIMAL  SLIGHT  MODERATE  SEVERE | **FREQUENCY:**  INTERMITTENT  OCCASSIONAL  FREQUENT  CONSTANT

**DESCRIBE THE FEELING:**  DULL  SHARP  ACHING  SHOOTING  SPASM  THROBBING  BURNING  
 NUMB  TINGLING  OTHER

**LOCATION OF PAIN:**  RIGHT  LEFT  FRONT  BACK  OTHER \_\_\_\_\_

**ACTIONS THAT AFFECT THIS PAIN: (B) BRINGS PAIN ON (A) AGRAVATES THE PAIN (R) RELIEVES THE PAIN**

IN THE MORNING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	IN THE AFTERNOON: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	BENDING FORWARD: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
BENDING BACK: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	BENDING LEFT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	BENDING RIGHT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
TWISTING RIGHT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	TWISTING LEFT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	COUGHING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
SNEEZING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	STRAINING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	STANDING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
LIFTING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	SITTING: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	HEAT: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
COLD: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	REST: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	LYING DOWN: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
MEDICATIONS: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R		

OTHER 1: \_\_\_\_\_  B  A  R

**PAIN RADIATES TO:**

HEAD:  RIGHT  LEFT | NECK:  RIGHT  LEFT | SHOULDER:  RIGHT  LEFT  
 ARM:  RIGHT  LEFT | HAND:  RIGHT  LEFT | HIP:  RIGHT  LEFT  
 LEG:  RIGHT  LEFT | FOOT:  RIGHT  LEFT

PAIN ALSO RADIATES TO: \_\_\_\_\_

**ADDITIONAL COMMENTS:** \_\_\_\_\_

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## PAST MEDICAL HISTORY

(eg. Heart disease, stroke, diabetes, cancer, thyroid, asthma, ulcer etc.)

Please list the conditions for which you have had medical treatment in the past

PAST MEDICAL HISTORY 1: \_\_\_\_\_  
PAST MEDICAL HISTORY 2: \_\_\_\_\_  
PAST MEDICAL HISTORY 3: \_\_\_\_\_  
PAST MEDICAL HISTORY 4: \_\_\_\_\_  
PAST MEDICAL HISTORY 5: \_\_\_\_\_  
PAST MEDICAL HISTORY 6: \_\_\_\_\_  
PAST MEDICAL HISTORY 7: \_\_\_\_\_  
PAST MEDICAL HISTORY 8: \_\_\_\_\_

## PAST SURGICAL HISTORY

Please list any surgeries you have had include the year of the surgery.

PAST SURGICAL HISTORY 1: \_\_\_\_\_  
PAST SURGICAL HISTORY 2: \_\_\_\_\_  
PAST SURGICAL HISTORY 3: \_\_\_\_\_  
PAST SURGICAL HISTORY 4: \_\_\_\_\_  
PAST SURGICAL HISTORY 5: \_\_\_\_\_  
PAST SURGICAL HISTORY 6: \_\_\_\_\_  
PAST SURGICAL HISTORY 7: \_\_\_\_\_  
PAST SURGICAL HISTORY 8: \_\_\_\_\_

## PAST FAMILY HISTORY

Please list major health conditions that your mother, father and/or grandparents has been diagnosed with

PAST FAMILY HISTORY 1: \_\_\_\_\_  
PAST FAMILY HISTORY 2: \_\_\_\_\_  
PAST FAMILY HISTORY 3: \_\_\_\_\_  
PAST FAMILY HISTORY 4: \_\_\_\_\_  
PAST FAMILY HISTORY 5: \_\_\_\_\_  
PAST FAMILY HISTORY 6: \_\_\_\_\_  
PAST FAMILY HISTORY 7: \_\_\_\_\_  
PAST FAMILY HISTORY 8: \_\_\_\_\_

## CURRENT MEDICATIONS

Please list medications you are currently taking

CURRENT MEDICATIONS 1: \_\_\_\_\_  
CURRENT MEDICATIONS 2: \_\_\_\_\_  
CURRENT MEDICATIONS 3: \_\_\_\_\_  
CURRENT MEDICATIONS 4: \_\_\_\_\_  
CURRENT MEDICATIONS 5: \_\_\_\_\_

## SOCIAL HISTORY

MARITAL STATUS:

MARRIED  SINGLE  
 WIDOWED  DIVORCED  
 SEPARATED

CHILDREN: \_\_\_\_\_

ARE YOU CURRENTLY PREGNANT?

YES  NO IF YES, \_\_\_\_\_ MONTHS

## HOW MUCH OF EACH DO YOU USE/DO IN A WEEK:

TOBACCO \_\_\_\_\_ PACKS PER WEEK  ALCOHOL \_\_\_\_\_ DRINKS PER WEEK  
 ALCOHOL \_\_\_\_\_ DRINKS PER WEEK  EXERCISE: \_\_\_\_\_ HOURS PER WEEK  
 COFFEE \_\_\_\_\_ CUPS PER WEEK

DOMINANCE:  RIGHT HANDED  LEFT HANDED  AMBIDEXTROUS

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## Authorization and Informed Consent to Perform Health Examinations, Diagnostic Testing and Treatment

I hereby request and consent to the performance of health examinations, diagnostic testing and treatment, which may include various modes of physical therapy and chiropractic, diagnostic x-ray, diagnostic ultrasound, nerve conduction studies, or any other necessary diagnostic or therapeutic procedures on me ( or on the patient named below, for whom I am legally responsible) by the qualified staff of The Chiropractic Center Of Marietta.

I understand and I am informed that in the practice of health care, there are some risks to examination, diagnostic testing and treatment including, but not limited to: exposure to radiation, injury by electric current, disc injuries, fractures, strokes, dislocations, sprains and strains. I have had an opportunity to discuss with the staff/doctor of The Chiropractic Center of Marietta the risks, nature and purpose for any and all examinations, diagnostic tests or treatment. I do not expect the staff to be able to anticipate and explain all associated risks and complications. I hereby authorize the staff to exercise judgment for my health care ( or on the patient named below, for whom I am legally responsible), based upon the facts currently known about my health status, or the current health status of the patient named below. I understand that any physical problem which is not within the scope of practice of the health care staff at the Chiropractic Center of Marietta, will be referred or deferred to a more qualified health care provider.

I also understand that the Chiropractic Center of Marietta does provide health care for some patients in an open room setting, and my health care information may be overheard by others. I agree to hold the staff harmless for any health information overheard by others while under care.

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

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

\_\_\_\_\_  
Print Name of Patient's Guardian or Parent

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Patient's Guardian or Parent

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date Signed

To the best of my knowledge I am NOT pregnant and the staff at the Chiropractic Center of Marietta has my permission to perform x-ray(s) on me for diagnostic interpretation. I agree to hold harmless the Chiropractic Center of Marietta, and all of its health care practitioners for any and all damages occurred as a result of x-ray exposure.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

# Chiropractic Center of Marietta

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## OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office is pleased to accept insurance assignment as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Our office policy with regards to assignments is as follows:

1. By taking your insurance assignment, we have to wait for payment. This courtesy may be withdrawn if circumstances warrant it.
2. If you discontinue care without the doctor's authorization, the balance of your account is due and payable in full immediately.
3. Your insurance should pay within 30 days. If your insurance has not paid within 90 days, you must pay the balance due and be reimbursed by your insurance when and if it pays.
4. We will bill your insurance on 7 to 14 day cycles as long as you are receiving Medical Care in this office.
5. You agree to pay the percentage of your responsibility as you go along, unless other arrangements are made with our office manager, prior to treatment.
6. You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance.
7. Our office DOES NOT guarantee that your insurance will pay. Although we will make every attempt at the beginning of your health care to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill.
8. Our office WILL NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. We will however, provide you and your insurance company with all the necessary information to process your claim.
9. If you understand and agree with all of the above office policies please sign your name below and we will accept your insurance.

DATE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

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## CONFIDENTIALITY NOTICE

Because it is important for us to honor the confidentiality between patient and doctor, you are asked to consider whether you wish for your medical concerns to be discussed with your family members, should your doctor be contacted by them.

Please realize, of course, that by law it is required that we release requested medical information to your insurance company and others that request it.

### PLEASE CHECK YOUR PREFERENCE BELOW:

\_\_\_\_\_ Discuss my medical concerns with me only.

\_\_\_\_\_ It is permissible to discuss my medical concerns with the following  
People should they contact my doctor.

1. \_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_ It is permissible to leave medical information on your answering  
machine.

I understand that a written request by me will be required to alter the above, and I will note specifically with whom my doctor may discuss my case.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date