PATIENT INFORMATION

ATLANTA CHIROPRACTIC & WELLNESS CENTER

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Full Name _____ Home Phone_____

Address _____City_____ State_____ Zip_____

Age _____Birth Date _____ Marital Status (Circle One): **S M W D Sep** No. Children_____

SS#_____ email _____

Your Employer _____Your Occupation _____Years on Job _____

Employer Address _____City_____ State _____Zip_____

Work Phone _____ Cell Phone _____ (Cell Carrier)_____

Name of Spouse, Parent or Guardian _____ Age ____ Birth Date_____ SS#_____

Spouse's Employer _____Spouse's Occupation_____ Years on Job _____

Employer Address _____City_____ State _____Zip_____

Work Phone _____

How did you find out about our office? _____

Who is your Medical Doctor?_____

Is your condition due to an accident? ☐**Yes** ☐**No** Date of your accident: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care pan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original. I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature_____ Date _____

Spouse's or Guardian's Signature _____ Date _____

FULL NAME_____ DATE_____ AGE_____ HEIGHT_____ WEIGHT_____

WHAT IS YOUR CHIEF COMPLAINT?_____

NO PHYSICAL COMPAINTS AT THIS TIME: ☐

☐ Confusion	☐ Neck Pain	☐ Lower Back Pain
☐ Depression	☐ Neck Restriction	☐ Lower Back Stiffness
☐ Dizziness	☐ Neck Stiffness	☐ Constipation
☐ Blurred/Double Vision	☐ Pins & Needles in Arms: Right Left Both	☐ Pins & Needles in Legs: Right Left Both
☐ Ears Ringing/Buzzing	☐ Pins & Needles in Hands: Right Left Both	☐ Other:
☐ Eye Strain/Pain	☐ Shoulder Pain: Right Left Both	
☐ Fainting	☐ Elbow Pain: Right Left Both	
☐ Fear	☐ Hand Pain: Right Left Both	
☐ Headache	☐ Knee Pain: Right Left Both	
☐ Head Seems Heavy	☐ Ankle Pain: Right Left Both	
☐ Irritability	☐ Foot Pain: Right Left Both	
☐ Loss of Memory	☐ Upper Back Pain	
☐ Loss of Smell	☐ Upper Back Stiffness	
☐ Loss of Taste	☐ Rib Pain	
☐ Mental Dullness	☐ Mid-back Pain	
☐ Nervousness	☐ Mid-back Stiffness	
☐ Tension	☐ Chest Pain	
☐ Unbalanced	☐ Feet/Hands Cold	

HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENT IN THE LAST YEAR? YES ☐ NO ☐

IF SO, IS THIS CONDITION RELATED? YES ☐ NO ☐

HAS THE PROBLEM INTERRUPTED YOUR SLEEP? YES ☐ NO ☐

DOES ANYONE IN YOUR FAMILY HAVE THE SAME OR SIMILAR CONDITION? YES ☐ NO ☐

IF SO, WHO: _____

LIST ANY OTHER DOCTORS OR THERAPISTS THAT YOU HAVE SEEN FOR THIS COMPLAINT:

_____ SPECIALTY:_____

RELEVANT MEDICAL HISTORY: (Please check the conditions you have or have had previously)

☐ Arthritis	☐ Epilepsy	☐ Muscular Dystrophy
☐ Asthma	☐ Fibromyalgia	☐ Neck Pain or Spasms
☐ Anemia	☐ Hand or Wrist Pain	☐ Neuritis
☐ Back Pain or Spasm	☐ Headaches	☐ Numbness
☐ Cancer	☐ Heart Problems	☐ Polio
☐ Concussion	☐ Hepatitis	☐ Rheumatic Fever
☐ Convulsion	☐ High Blood Pressure	☐ Sinus Trouble
☐ Diabetes	☐ HIV	☐ Sciatica
☐ Digestion Problems	☐ Measles	☐ Tuberculosis (TB)
☐ Dizziness	☐ Multiple Sclerosis	☐ Venereal Disease

LIST ANY SURGERIES THAT YOU HAVE HAD AND APPROXIMATE DATES:

1. _____ DATE: _____ DR: _____
2. _____ DATE: _____ DR: _____
3. _____ DATE: _____ DR: _____

FULL NAME_____ DATE_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☐

ARE YOU TAKING ANY MEDICATIONS FOR THIS OR ANY OTHER COMPLAINT? YES ☐ NO ☐

ARE YOU PREGNANT? YES ☐ NO ☐ IF YES, DUE DATE:_____

FAMILY HISTORY: HEART DISEASE ☐ ARTHRITIS ☐ CANCER ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐

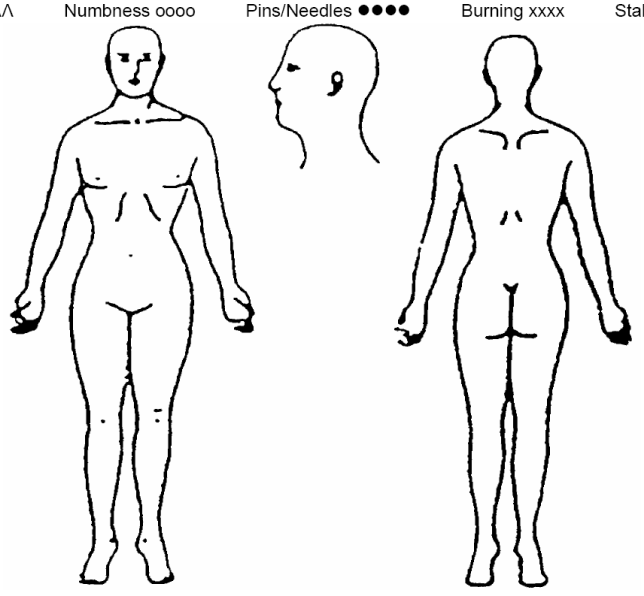
DO YOU: SMOKE: YES ☐ NO ☐ IF YES, AMOUNT PER DAY:_____

DRINK: YES ☐ NO ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐

DRUGS: YES ☐ NO ☐

SYMPTOMS DIAGRAM

Aches ^^^^ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



ON A SCALE FROM 1 – 10, 1 BEING THE LEAST AMOUNT OF SYMPTOMS AND 10 BEING THE WORST, PLEASE INDICATE THE SEVERITY REGARDING THE FOLLOWING QUESTIONS:

How bad are your symptoms now?	1	2	3	4	5	6	7	8	9	10
How bad have they been in the past?	1	2	3	4	5	6	7	8	9	10
What are the symptoms at their worst?	1	2	3	4	5	6	7	8	9	10
What are the symptoms at their best?	1	2	3	4	5	6	7	8	9	10
How bad are your symptoms on average?	1	2	3	4	5	6	7	8	9	10

ARE YOU HERE FOR :

RELIEF CARE ☐ (Gets rid of symptoms or pain, but not cause)

CORRECTIVE CARE ☐ (Gets rid of symptoms and corrects cause. Varies in length of time, but is more lasting.)

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score