Welcome to

Chiropractic Healthcare of Buckhead

Thank you for choosing our office! We are committed to providing you and your family with the highest quality of chiropractic care available so that you heal quickly and enjoy an active, healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. Chiropractors have become the primary care doctors for millions of people around the world. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime!

Consent to Care:

_____ I do hereby authorize the Doctor of Chiropractic Healthcare of Buckhead to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure, which is advisable, and necessary for my healthcare. In addition to this agreement, I hereby authorize Chiropractic Healthcare of Buckhead and/or any of its doctors to release my medical records as is deemed necessary for further treatment, second opinions, legal issues, and insurance matters.

_____ I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

_____ I authorize Chiropractic Healthcare of Buckhead and/or its doctors to bill my insurance under the condition of insurance assignment. I understand that any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally responsible for any and all of the unpaid balance to the doctor.

I, _____have read, understand, and hereby request chiropractic care based on the above agreement.

Signature: _____ Date: _____

Signature of parent or guardian (if minor): _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

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.

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 the 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.

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 evaluation, 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)

Personal and Family Health History

*Starred items are a part of the ARRA HITECH Act of 2009, and must be completed to meet government electronic health record (EHR) standards. Thank you!

Name_____
Date _____
Address_____
City _____ State _____ Zip _____
Phone: (H) _____ (W) _____
E-mail _____
***Preferred contact method**_____
Date of Birth _____ (Age _____)
Referred By_____

Social Security # _____
Occupation _____
Employer _____
Marital Status S M D W
Spouse's Name _____
Spouse's Occupation _____
Emergency Contact name and number_____
_____

***Verification Question (Please choose one):** □What is the name of your favorite pet? □In what city were you born? □What high school did you attend? □What is your favorite movie? □What is your mother's maiden name? □When is your anniversary? □What was the make of your first car? □On what street did you grow up?

Answer to the Verification Question: _____

***Ethnicity (check one)** □Hispanic of Latino □Non-Hispanic or Latino □I choose not to specify

***Race (check one)**

□White
□Asian
□Japanese
□Samoan
□Black/African American
□Korean
□Guamanian
□Hispanic
□Chinese
□Vietnamese
□American Indian/ Alaskan Native
□Filipino
□Native Hawaiian/Pacific Islander
□Other
□Multiracial
□Choose not to specify

***Preferred Language (check one)**

□English
□Tagalog
□Arabic
□Persian
□Spanish
□Korean
□German
□Portuguese
□Chinese
□Vietnamese
□Sign Language
□Italian
□French
□Armenian
□Other
□Russian
□Greek
□Polish
□Hindi
□Choose not to specify

Number of Children and Ages

Name _____
Name _____
Name _____
Name _____

Previous Chiropractic Care?

Age _____ Yes___ No___ Reason _____
Age _____ Yes___ No___ Reason _____
Age _____ Yes___ No___ Reason _____
Age _____ Yes___ No___ Reason _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

Please Circle all that Apply	***Patient***	***Spouse***	***Child #1***	***Child #2***	***Child #3***	***Comments***
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	
Difficult Delivery?	Y	Y	Y	Y	Y	
Forceps?	Y	Y	Y	Y	Y	
Caesarian?	Y	Y	Y	Y	Y	
Breach/cephalic?	Y	Y	Y	Y	Y	
Home birth?	Y	Y	Y	Y	Y	
Mother given drugs during delivery	Y	Y	Y	Y	Y	
Induced Labor?	Y	Y	Y	Y	Y	
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	
Fall out of bed?	Y	Y	Y	Y	Y	
Bang your head?	Y	Y	Y	Y	Y	
Breastfeed?	Y	Y	Y	Y	Y	
Childhood sickness?	Y	Y	Y	Y	Y	
Have any Accidents?	Y	Y	Y	Y	Y	
Have Surgery?	Y	Y	Y	Y	Y	
Take Drugs?	Y	Y	Y	Y	Y	
Fall while learning to walk?	Y	Y	Y	Y	Y	
Bullied by your siblings?	Y	Y	Y	Y	Y	
Child abuse	Y	Y	Y	Y	Y	
Spanking?	Y	Y	Y	Y	Y	
Pulled ear/chin	Y	Y	Y	Y	Y	
Other	Y	Y	Y	Y	Y	
Chair pulled out when sitting?	Y	Y	Y	Y	Y	
Fall down the stairs?	Y	Y	Y	Y	Y	
Pulled by your arm?	Y	Y	Y	Y	Y	
Experience other traumas?	Y	Y	Y	Y	Y	
3. Current Health Habits						
Did/do you...						
***Ever Smoke?**	Y	Y	Y	Y	Y	
If yes how often? _____						
Interest level in quitting smoking?	1 2 3 4 5 6 7 8 9 10 Not Interested ... Very Interested					
Drink?	Y	Y	Y	Y	Y	
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	
Get 10-12 fruits and veggies daily?	Y	Y	Y	Y	Y	
Have you been in accidents?	Y	Y	Y	Y	Y	
Have you had surgery	Y	Y	Y	Y	Y	
organs replaced/removed?	Y	Y	Y	Y	Y	
Drugs? (Prescriptive or Non)	Y	Y	Y	Y	Y	
Have Teeth Problems?	Y	Y	Y	Y	Y	
Have Eye Problems?	Y	Y	Y	Y	Y	
Have Hearing Problems?	Y	Y	Y	Y	Y	
Exercise regularly?	Y	Y	Y	Y	Y	
Have sleeping problems?	Y	Y	Y	Y	Y	
Have occupational stress?	Y	Y	Y	Y	Y	
Have physical stress?	Y	Y	Y	Y	Y	
Have mental stress?	Y	Y	Y	Y	Y	
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	
Sleeping posture?	side	stomach	back			

Current Health Condition ***Name***_____ ***Date***_____

Present Complaint or Crisis? (if more than one, please list in order of importance)

_____

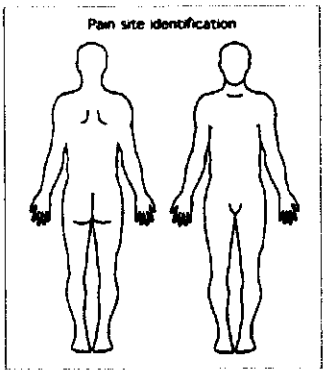
If no current crisis, what is the reason for your visit today? (Please Circle)

Performance/Sport Care Re-committing to Lifestyle Care Re-exam

Pain or Problem started on_____

Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent
❒ Throbbing ❒ Burning ❒ Numb/Tingling ❒ Stabbing
❒ Deep ❒ Aching ❒ Radiating, if so where? _____

Pain Severity (please circle): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)
What % of the day do you feel pain? 10 20 30 40 50 60 70 80 90 100%
How long does each episode hurt when you are in pain? _____



Please indicate areas of pain on the chart above.

What activities aggravate your condition/pain?

❒Sitting ❒Looking up/down ❒Typing ❒Twisting
❒Standing ❒Movement ❒Household Chores ❒Coughing
❒Sleeping ❒Rest ❒Exercise ❒Straining
❒Sneezing ❒Driving ❒Stairs

What activities lessen your condition/pain?

❒Sitting ❒Knees Bent ❒Ice ❒Adjustments
❒Standing ❒Movement ❒NSAIDs (Advil, etc.) ❒Massage
❒Lying down ❒Rest ❒Exercise ❒Analgesic Ointment
❒Support ❒Heat ❒Stretching

Is condition worse during certain times of the day? _____Morning? ____ _____Night? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Is this condition getting progressively worse? _____
Other Doctors seen for this condition _____
Any home remedies? _____

Other symptoms:

❒ Headaches ❒ Face Flushed ❒ Light Bothers Eyes ❒ Feet Cold
❒ Neck Pain ❒ Neck Stiff ❒ Loss of Memory ❒ Hands Cold
❒ Sleeping Problems ❒ Pins & Needles in Legs ❒ Ears Ring ❒ Stomach Upset
❒ Back Pain ❒ Pins & Needles in Arms ❒ Fever ❒ Constipation
❒ Nervousness ❒ Numbness in Fingers ❒ Fainting ❒ Loss of Balance
❒ Tension ❒ Numbness in Toes ❒ Cold Sweats ❒ Buzzing in Ear
❒ Irritability ❒ Shortness of Breath ❒ Loss of Smell ❒ Other_____
❒ Chest Pains ❒ Fatigue ❒ Loss of Taste _____
❒ Dizziness ❒ Depression ❒ Diarrhea

You been under drug and medical care? _____

* Have **Primary Care Physician's Name** _____**Phone #** _____

***Office Name**_____

***Address**_____ **City**_____ **State**_____

***What medications are you taking?** _____

_____

***Any known medication allergies?** _____

Have you had surgery? What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

***Have you been diagnosed with hypertension?** □Yes □No ***Diabetes (I or II)?** □Yes □No
***Had an x-ray, CT, or MRI in the past 28 days?** □Yes □No

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Your oldest grandparent on record lived to the age of _____.
❒ Still living ❒ Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

❒ Feel better quickly
❒ Have a healthier spine and nervous system
❒ Live a healthier lifestyle

_____ _____
Signature Date