12540 Broadwell Road, Suite 2102
Milton, GA 30004
770-751-9224

Name: ______________________ Date of Birth:____________ Age:________

Address:______________________ City:______________ Zip:________

Home Phone:______________ Work Phone:______________ Cell Phone:______________

Email:______________________

Marital Status:

□ Married Spouse's Name:______________
□ Single
□ Divorced
□ Widowed

Number of Children:________ Ages:____________

How did you hear about us?

□ Friend who is a patient ______________________
□ Internet Search □ Flyer
□ Facebook □ Twitter
□ Drive By
□ Other:______________________

Your Employer:______________________ Occupation:______________________

Who is responsible for your bill? □ Self □ Spouse □ Medicare □ Health Insurance □ Auto Insurance

Health Insurance Company: ______________ Name of Primary:______________

Primary Date of Birth:______________ Primary SSN:______________

1. **Reason for Chiropractic Care**:______________________________

2. **Is your condition**: □ the result of an accident of injury? □ Work □Auto □Other______________
□ a worsening long term problem?

3. **Onset**: When did you first notice your symptoms?

____

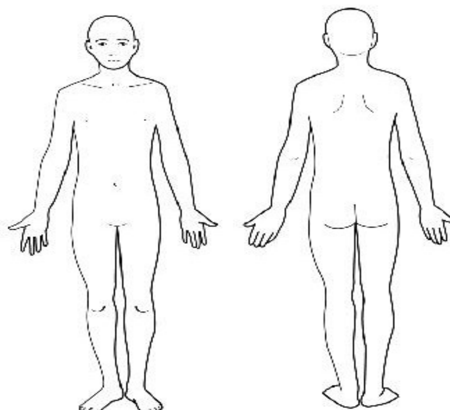
6. **Quality of Symptoms**: What does it feel like?

□ Numbness
□ Tingling
□ Stiffness
□ Dull
□ Aching
□ Cramping
□ Nagging
□ Sharp
□ Burning
□ Shooting
□ Throbbing
□ Stabbing
□ Other ______________

4. **Intensity**: How extreme are your symptoms?

1 5 10
□ - □ - □ - □ - □ - □ - □ - □ - □ - □
Absent Painful Agonizing

7. **Location**: Where does it hurt?
X = current condition O= Past condition



5. **Duration/Timing**: When and how often do you feel it? □ Constant □ Sometimes

Worse in the: □ Morning □ Evening

Better in the: □ Morning □ Evening

8. **Radiating**: To what area does the pain radiate, shoot, or travel?

____

9. **Aggravating/Relieving Factors**: What makes is worse such as time of day, movement, or certain activities?

What worsens the problem?

____

What lessens the problem?

____

10. **Prior Interventions**: What have you done to relieve the symptoms?

□ Medication □ Surgery □ Ice/Heat □ Acupuncture
□ Homeopathic Remedies □ Chiropractic □ Physical Therapy □ Massage
□ Stretching/Exercise □ Other ________________

11. **What else should the doctor know about your condition**?

____

12. **How does your current condition interfere with your**:

Work or career:____

Recreational activities:____

Household Chores:____

Personal Interactions: ____

13. **Review of Systems**: Chiropractic care focuses on the integrity of your nervous system which controls and regulates you entire body. Please check beside any condition that you have NOW or had in the PAST.

Musculoskeletal

Now Past

□ □ Osteoporosis
□ □ Arthritis
□ □ Scoliosis
□ □ Neck Pain
□ □ Back Problems
□ □ Hip Disorders
□ □ Knee Injuries
□ □ Leg Pain
□ □ Poor Posture
□ □ Arm Pain
□ □ TMJ
□ □ Shoulder Pain

Endocrine

Now Past

□ □ Thyroid Issues
□ □ Immune Disorders
□ □ Hypoglycemia
□ □ Frequent Infection
□ □ Swollen Glands
□ □ Low Energy

Neurological

Now Past

□ □ Anxiety
□ □ Depression
□ □ Headache
□ □ Dizziness
□ □ Pins/Needles
□ □ Numbness

Digestive

Now Past

□ □ Anorexia/Bulimia
□ □ Ulcer
□ □ Food Sensitivities
□ □ Heartburn
□ □ Constipation of Diarrhea
□ □ Ulcerative Colitis

Genitourinary

Now Past

□ □ Kidney Stones
□ □ Infertility
□ □ Kidney Dysfunction
□ □ Prostrate Problems
□ □ Erectile Dysfunction
□ □ PMS Symptoms

Cardiovascular

Now Past

□ □ High Blood Pressure
□ □ Low Blood Pressure
□ □ High Cholesterol
□ □ Poor Circulation
□ □ Angina
□ □ Excessive Burning

Sensory

Now Past

□ □ Blurred Vision
□ □ Ringing in the ears
□ □ Hearing Loss
□ □ Chronic Ear Infections
□ □ Loss of Smell
□ □ Loss of Taste

Constitutional

Now Past

□ □ Fainting
□ □ Low Libido
□ □ Poor Appetite
□ □ Fatigue
□ □ Sudden Weight Change
□ □ Weakness

Respiratory

Now Past

□ □ Asthma
□ □ Apnea
□ □ Emphysema
□ □ Hay Fever
□ □ Shortness of Breath
□ □ Pneumonia

Integumentary

Now Past

□ □ Skin Cancer
□ □ Psoriasis
□ □ Eczema
□ □ Acne
□ □ Hair Loss
□ □ Rash

Past, Personal, Family, and Social History

Please identify your past health history, including accidents, injuries, illnesses, and treatments

14. **Illnesses**

Now Past	Now Past	Now Past	Now Past	Now Past	Now Past
□ □ Aids	□ □ Alcoholism	□ □ Allergies	□ □ Arteriosclerosis	□ □ Cancer	□ □ Diabetes
□ □ Epilepsy	□ □ Heart Disease	□ □ Hepatitis	□ □ Multiple Sclerosis	□ □ Mumps/Polio	□ □ STD
□ □ Stroke	□ □ Ulcer	□ □ Other:_____________________			

15. **Surgery**

Now Past	Now Past	Now Past	Now Past	Now Past
□ □ Appendectomy	□ □ Bypass Surgery	□ □ Cancer	□ □ Cosmetic Surgery	□ □ Elective Surgery:__________
□ □ Eye Surgery	□ □ Hysterectomy	□ □ Pacemaker	□ □ Spine	□ □Tonsillectomy
□ □ Other: ____________________				

16. **Treatments**

Check the ones you are receiving now or have in the past received.

Now	Past
☐	☐ Acupuncture
☐	☐ Antibiotics
☐	☐ Birth Control Pills
☐	☐ Blood Transfusions
☐	☐ Chemotherapy
☐	☐ Chiropractic Care
☐	☐ Dialysis
☐	☐ Herbs
☐	☐ Homeopathy
☐	☐ Hormone Replacement
☐	☐ Inhaler
☐	☐ Massage Therapy
☐	☐ Physical Therapy
☐	☐Nutritional Supplements ______________________
☐	☐ Medications (list) ______________________ ______________________ ______________________

17. **Injuries**

Have you ever...

☐ Had a fracture or broken bone
☐ Had a spinal nerve disorder
☐ Been knocked unconscious
☐ Been injured in an accident
☐ Used a crutch or other support
☐ Used neck or back bracing
☐ Received a tattoo
☐ Had a body piercing

18. **Family History**

Please give the history of your immediate family members

Relative	State of Health Good	Poor	Illnesses
Mother	☐	☐	____________________________
Father	☐	☐	____________________________
Sister	☐	☐	____________________________
Brother	☐	☐	____________________________

19. **Are there any other hereditary health issues that you know about?**____

20. **Lifestyle History**

Alcohol Use	☐ Daily	☐ Weekly	How much? ___________
Coffee Use	☐ Daily	☐ Weekly	How much? __________
Tobacco Use	☐ Daily	☐ Weekly	How much? _________
Exercise	☐ Daily	☐ Weekly	Type _______________
Water	☐ Daily	☐ Weekly	How much? __________
Vitamins	☐ Daily	☐ Weekly	Type _______________

Females: Is it possible that you are pregnant? ☐ Yes ☐ No

First day of last cycle: __________

21. What is the primary stressor in your life? _________________

22. In what position do you sleep most often? ________________

23. What would be the most significant thing you could do to improve your health? _____________________________________

24. Do you have any specific health goals? ____

25. How much sleep do you get per night?_______________

26. Do you drink a half gallon of water daily? Y N

27. **Activities of Daily Living**

How does your condition interfere with your ability to function?

	No Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐
Rising out of chair	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Lying down	☐	☐	☐
Bending over	☐	☐	☐
Climbing stairs	☐	☐	☐
Using a computer	☐	☐	☐
Getting in/out of a car	☐	☐	☐
Driving	☐	☐	☐
Looking over shoulder	☐	☐	☐
Caring for family	☐	☐	☐

	No Effect	Moderate Effect	Severe Effect
Grocery Shopping	☐	☐	☐
Household chores	☐	☐	☐
Lifting Objects	☐	☐	☐
Reaching overhead	☐	☐	☐
Showering/Bathing self	☐	☐	☐
Getting to sleep	☐	☐	☐
Staying asleep	☐	☐	☐
Concentrating	☐	☐	☐
Exercising	☐	☐	☐
Yard work	☐	☐	☐
Endurance	☐	☐	☐

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, to detect and correct/reduce the vertebral subluxation complex. It is important to each patient to understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method 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 nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express maximum health potential.

Patient Inform Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities of physical therapies and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/ or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, included but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/ her, is in my best interest.

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

Healthcare Authorization and Privacy Policy

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Milton Chiropractic and Massage to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Milton Chiropractic and Massage to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications , birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If Milton Chiropractic and Massage contacts me by phone, I give them permission to leave a phone message on my answering or voice mail.
- I give permission to Milton Chiropractic and Massage to use my testimonial written by me for marketing purposes, such as sharing with other patients or potential patients, in their brochures, on their website, or in ads in print media.
- I give Milton Chiropractic and Massage permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some on my protected health information during the course of care. Should I need to speak with my doctor at any time in private the doctor will provide a room for these conversations.
- By signing this form I am giving Milton Chiropractic and Massage permission to use and disclose my protected health information in accordance with the directives listed above.

The use of this format is intended to make my experience with Milton Chiropractic and Massage's office more efficient and productive, as well as to enhance my access to quality health care and health information. This authorization will remain in effect for the duration of my care at MIlton Chiropractic and Massage, plus 7 years or until revoked by me.

AUTHORIZATION AND ASSIGNMENT—AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his/ her staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/ her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original. Due to changes in United Healthcare coverage all patients utilizing UHC insurance for care will be responsible for the cost of the initial exam and any needed x-rays. These changes are effective as of Novemeber 1st, 2015.

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official at Milton Chiropractic and Massage. The written notice must contain the following information: Your name, Social Security Number, a date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Milton Chiropractic and Massage for its own use/disclosure of PHI. (*Minimum necessary standards apply*)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Milton Chiropractic and Massage will not refuse to provide treatment however, it will not be possible for Milton Chiropractic and Massage to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Milton Chiropractic and Massage will e unable to contact me 3) all contact with Milton Chiropractic and Massage regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form, the Right to Revoke Authorization Form, and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Milton Chiropractic & Massage: Dana Harvey, D.C.

Social Security Number: XXX-XX-______	Date of Birth:
Patient Name: (please print)	
Patient’s signature (or parent or guardian):	Date:
Name of personal representative (if applicable)	
Description of representative's authority to act on patient’s behalf:	
Representative’s Signature:	Date: