

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 _____

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

WHO REFERRED YOU? _____

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DESCRIBE YOUR PRIMARY COMPLAINT:

WHAT HURTS? _____

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

How bad does it hurt:

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 THROBING 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 LEFT: <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	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 TRAVELS FROM PRIMARY COMPLAINT 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 TRAVELS TO: _____

ADDITIONAL COMMENTS: _____

DESCRIBE YOUR SECOND COMPLAINT:

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 THROBING 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 LEFT: <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	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 TRAVELS FROM SECONDARY COMPLAINT 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 TRAVELS TO: _____

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ADDITIONAL COMMENTS: _____

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: _____

NONE

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: _____

NONE

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: _____

NONE

CURRENT MEDICATIONS

Please list medications you are currently taking

CURRENT MEDICATIONS 1: _____

CURRENT MEDICATIONS 2: _____

CURRENT MEDICATIONS 3: _____

CURRENT MEDICATIONS 4: _____

CURRENT MEDICATIONS 5: _____

NONE

SOCIAL HISTORY

MARITAL STATUS:

- MARRIED SINGLE
 WIDOWED DIVORCED
 SEPARATED

CHILDREN: _____

ARE YOU CURRENTLY PREGNANT?

YES NO IF YES, _____ WEEKS

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

TOBACCO _____ PACKS PER WEEK FOR _____ YEARS. QUIT? WHEN? _____

ALCOHOL _____ DRINKS PER WEEK EXERCISE: _____ HOURS PER WEEK

COFFEE _____ 8 oz. CUPS PER WEEK WHAT KIND OF EXERCISE? _____

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 for 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

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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