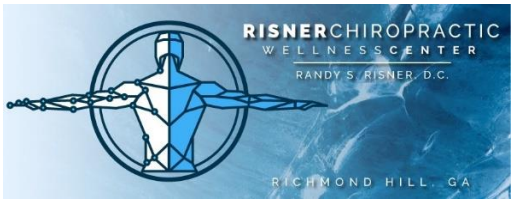


APPLICATION FOR CARE

Date of Initial Visit: _____

Patient Demographics:

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: ____ Zip: _____ Phone: _____

D.O.B.: _____Gender: _____ Email: _____

Marital Status: ☐S ☐M ☐W ☐D Spouses Name: _____ D.O.B.: _____

Employment Information:

Employment status: _____ Professional title: _____

Employer name: _____ Employer phone: _____

Employer address: _____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

***Notice to our new patients: Full payment for services rendered is due before each visit. If for any reason this request cannot be met, arrangements should be made before seeing the doctor.**

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. **I understand and agree that health and auto insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services covered or not covered. I understand that it is also MY REPSONSIBILITY TO VERIFY my coverage with my insurance carrier.** I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me up to date of termination will be immediately due and paid. I also understand that if I have used a gift certificate or other special offer and films were obtained as part of my care and I terminate my care and request my file or health information to be sent to another provider that I must pay the full price for my films before they will be released.

*Insurance cases: On all insurance assignments your deductible must be met first unless prior arrangements are made.

**I hereby agree that if my bill has to be turned over to a third-party collection agency for non-payment, there will be a collection fee of 35% added to my bill. This is pursuant to Georgia Statutory Law “O.C.G.A.-13-1-11”.

Patient/Guardian Signature:_____ **Date:**_____

REFERRAL INFORMATION

Referring Physician: _____ Telephone Number: _____

Referring Patient: _____

Are you currently working with an attorney? ☐ Yes ☐ No

How did you hear about us? □ Word of Mouth □ Advertisement □ Social Media □ Internet

REASON FOR VISIT

What is your primary complaint? _____

How long have you had this complaint?

□ Less than 5 days (Acute)

□ Between 5-30 days (Sub Acute)

□ More than 30 days (Chronic)

What caused this condition? _____

Have you ever had any previous episodes of this condition? ☐ Yes ☐ No

What is the date this condition began? _____

Is this condition related to: **Work?** □ Yes □ No

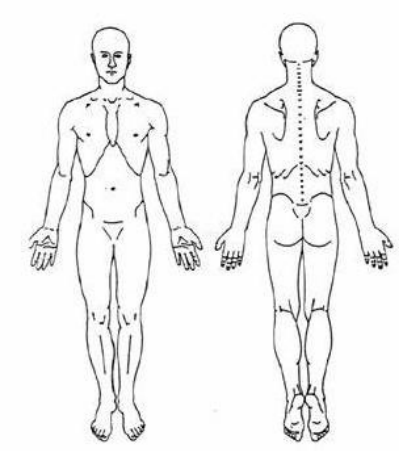
Has your employer been notified? □ Yes □ No

Motor Vehicle Accident? □ Yes □ No Date of Injury: _____

What treatment, if any, have you received since the accident?

_____

What term(s) best describes your discomfort? _____



Please indicate your areas of symptoms by drawing in the appropriate symbols.

P- PAIN
N- NUMBNESS
W- WEAKNESS
S- SHOOTING
A- ACHING

On a scale of 1 to 10 being the most severe, how do you rate your discomfort?

None **Unbearable**

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort?

□ Constant □ Frequent □ Occasional □ Intermittent

How has this complaint changed since the onset?

□ Worsened □ Remained the same □ Improved

What activity is most significantly affected by this discomfort?

_____

What activity aggravates this condition?

_____

What improves this condition or gives relief?

_____

Have other health care providers performed tests related to this condition?

(If yes, explain) _____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints:	□ Yes □ No Explain_____
Nerves, Headaches, Dizziness, or Emotional:	□ Yes □ No Explain_____
Head, Eyes, Ears, Nose or Throat:	□ Yes □ No Explain_____
Heart, Blood Pressure, or Circulation:	□ Yes □ No Explain_____
Shortness of Breath, Coughing, Asthma or Lung Condition:	□ Yes □ No Explain_____
Stomach, Bowels or Digestive Conditions:	□ Yes □ No Explain_____
Genital, Bladder or Urinary Conditions:	□ Yes □ No Explain_____
Diabetes, Thyroid or Glandular Conditions:	□ Yes □ No Explain_____
Skin or Bleeding Conditions:	□ Yes □ No Explain_____
Allergies or Sensitivities:	□ Yes □ No Explain_____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures? □ Yes □ No Explain_____

Are there any past illnesses or conditions we should be aware of? □ Yes □ No Explain_____

Do you have a history of accidents or trauma? □ Yes □ No Explain_____

Are you currently taking any medication? □ Yes □ No Explain_____

Do you have a family illness history, such as diabetes, cancer, hypertension, and/or progressive neurological diseases that we should be aware of? □ Yes □ No Explain_____

WORK SOCIAL HABITS

(CHOOSE ALL THAT APPLY)

Current Work Habits:

□ **Permanently fully disabled** □ **Permanently partially disabled**
□ **Cannot work due to current condition**
□ **Full-Time (20-40+ hours/week)** □ **Part-Time (1-19 hours/week)**
□ **Retired** □ **Student** □ **Homemaker** □ **Unemployed**

Personal Social Habits:

□ **Smoke or use tobacco products**
□ **Drink alcohol**
□ **Drink caffeine**
□ **Use recreational drugs**
□ **Other, to be discussed with doctor**

Present Exercise Habits:

□ **No current exercises**
□ **Exercise daily**
□ **Exercise 3+ times per week**
□ **Cannot return to exercise due to current condition**

Diet and Nutrition Habits:

□ **Vegan or vegetarian**
□ **Daily supplements**
□ **Other**

INFORMED CONSENT TO TREAT

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctor sees fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will ne charged to me, and I am responsible for timely payment of suck services. I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient/Guardian Signature:_____ **Date:**_____