Adairsville Family Chiropractic
770.773.9997
323 North Main St. Adairsville GA

ABOUT THE PATIENT

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Birth date: _____

Cell Phone: _____ Work Phone: _____

Email: _____

Occupation: _____

Employer: _____

Work address: _____

Marital Status: _____

Do you have any children? Ages: _____

Social Security #: _____

Health Insurance: _____

ABOUT YOUR SIGINIFICANT OTHER/ EMERGENCY CONTACT

Name: _____

Employer: _____

Work phone: _____

Occupation: _____

REASON FOR THIS VISIT

* Describe the purpose of this visit: _____

_____

* When did this condition begin? _____

* What makes it better? _____

* What makes it worse? _____

* Does the pain

❑ Stay in one spot ❑ Radiate to other areas

* Type of pain

❑ Sharp/Stabbing ❑ Burning ❑ Pins and Needles

❑ Ache ❑ Numbness ❑ Other

* Has this condition

❑ Gotten worse ❑ Stayed constant ❑ Comes and goes

* Does this condition interfere with

❑ Work ❑ Sleep ❑ Daily routine ❑ Other activities

Please explain _____

* Has this condition occurred before? ❑ Yes ❑ No

Please explain _____

* Have you seen other doctors for this condition?

❑ Yes ❑ No

Doctor's Name(s): _____

Types of treatment: _____

Results: _____

Any other recent health concerns? _____

_____

MEDICATIONS I NOW TAKE

❑ Nerve pills ❑ Stimulants

❑ Blood thinners ❑ Tranquilizers

❑ Muscle relaxer ❑ Insulin

❑ Blood pressure medicine

❑ Pain killers (including aspirin)

❑ None

❑ _____

❑ _____

❑ _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Reason for those visits? _____

Doctor's name _____

Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? ❑ Yes ❑ No

Has any child in your family seen a Chiropractor? ❑ Yes ❑ No

* Were you aware that

- Doctors of Chiropractic work with the nervous system? ❑ Yes ❑ No
- The nervous system controls all bodily functions and systems? ❑ Yes ❑ No

HEALTH CONDITIONS

Please check each of the diseases or conditions you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall analysis, care plan and the possibility of being accepted for care.

- ❑ Headaches
- ❑ Ulcers/Colitis
- ❑ Sinus problems
- ❑ Dizziness
- ❑ Loss of sleep
- ❑ Pain between shoulders
- ❑ Frequent neck pain
- ❑ Numbness in Arms/legs/hands
- ❑ Pain in arms/legs/hands
- ❑ HIV/AIDS
- ❑ Heart surgery/ pacemaker
- ❑ Heart attack/stroke
- ❑ Heart murmur
- ❑ Congenital heart defect
- ❑ High/Low blood pressure
- ❑ Difficulty breathing
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Alcohol/drug abuse
- ❑ Surgeries
- ❑ Digestive problems
- ❑ Arthritis
- ❑ Diabetes
- ❑ Shingles
- ❑ Kidney problems
- ❑ Hepatitis
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Rheumatic fever
- ❑ Psychiatric problems
- ❑ Thyroid problems
- ❑ Lower back problems

*** For women:**

Are you pregnant?	❑ Yes	❑ No
Are you nursing?	❑ Yes	❑ No
Are you taking birth control?	❑ Yes	❑ No
Do you experience painful periods?	❑ Yes	❑ No
Do you have irregular cycles?	❑ Yes	❑ No

❑ Other(s): _____

CURRENT LIFESTYLE

Physical Dimension	No	Yes
Do you exercise regularly?	❑	❑
Are you stretching daily?	❑	❑
Are you interested in exercise?	❑	❑
Do you pay attention to posture?	❑	❑

Psychological Dimension	No	Yes
Do you feel "stressed out" regularly?	❑	❑
Do you practice relaxation/meditation techniques daily?	❑	❑
Do you handle stress in a positive way?	❑	❑
Is lack of time and/or energy during the day a source of stress for you?	❑	❑

Bio-Chemical Dimension	No	Yes
Do you eat prepared, processed or fast foods?	❑	❑
Do you smoke?	❑	❑
Do you consume caffeinated, carbonated, or drinks high in sugar daily?	❑	❑
Do you take nutritional supplements?	❑	❑

Overall	No	Yes
Are you satisfied with your current level of health?	❑	❑
Is your current level of health limiting you from doing things you enjoy?	❑	❑
Would you like help improving your current lifestyle?	❑	❑

GOALS FOR MY HEALTH

** PLEASE MARK ON THE CONTINUUM:

1. Where you feel you are now.
2. Where you want to be.

DISEASE	POOR HEALTH	MAINTAINING HEALTH	GOOD HEALTH	OPTIMAL HEALTH
Multiple Medications	Symptoms	No Symptoms	Regular Exercise	100% Function
Poor Quality of Life	Drug Therapy	Nutrition Inconsistent	Good Nutrition	Continuous Development
Potential Becomes Limited	Surgery	Exercise Sporadic	Wellness Education	Active Participation
Body has Limited Function	Losing Normal Function	Health Not High Priority	Minimal Nerve Interference	Wellness Lifestyle

I understand that all services are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature: _____ Date: _____