Flowery Branch Chiropractic

4875 Hog Mountain Road, Suite D, Flowery Branch, Georgia 30542
770-967-1900 / -1902 fax
www.flowerybranchchiro.com

Name: _____ Birthdate: ____/____/____ Sex: M / F

Address: _____ City: _____ State: _____ Zip Code: _____

Home # _____ Work # _____ Cell # _____

E-mail address: _____ Preferred language: _____

Preferred method of contact/communication for office appointments (please initial): Text _____ E-mail _____

Marital Status: Married _____ Divorced _____ Widowed _____ Single _____

Occupation: _____ Employer: _____ Yrs Employed: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Occupation: _____ Employer: _____

Emergency Contact & Phone: _____ & _____

Insurance Provider: _____ Subscriber/Member #: _____

Chief Complaint: _____

Cause of condition: _____

Have you had similar conditions in the past? YES / NO How did you hear about us? _____

ACCIDENT INFORMATION ***PLEASE NOTIFY THE FRONT DESK OF AUTO MEDPAY BENEFITS***

Did your accident occur on the job? YES / NO Injury reported to your employer? YES / NO

Were you involved in an automobile accident? YES / NO Date: _____ Time: _____

Do you have an attorney? YES / NO ... if YES; name/number: _____

"I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable."

Patient signature: _____ **Date:** _____

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Health History Form

Name: _____ Age: _____ Date of Birth: _____ Sex: _____

Patient's Chief Complaint:

_____

_____

Medications (List all medications currently prescribed):

_____

_____

Allergies (List all allergies/sensitivities):

_____

Patient's Past History: (Circle any if current or past experience)

Headaches, dizziness, fainting	Arthritis	Kidney Stones/Disease
Blurred vision	Chest Pain	Difficult/Painful Urination
Sinus trouble	High Blood Pressure	Easily Tired/Upset
Asthma	Heartburn/Indigestion	Depression
Sore Throats	Nausea/Vomiting	Convulsions
Shortness of Breath	Stroke	Back Pain/Injury
Persistent Cough	Ringing in Ears/Tinnitus	Diabetes
Night Sweats	Sudden Weight Loss/Gain	Prior Spinal Injuries

Serious Illness/Injuries/Hospitalizations	Date	Outcome

Patient's Family & Social History:

Do you use tobacco? YES / NO	Amount/How often _____
Do you use alcohol? YES / NO	Amount/How often _____
Do you exercise regularly? YES / NO	How often _____

Current Family Status:

Relation	Age	State of Health	Serious Illness(?) / Cause of Death
Father			
Mother			
Sibling(s)			

Patient Signature: _____ **Date:** _____

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ [redacted] _____ Plan ID _____ Total Score _____

PRINTED

_____

Signature

_____

Date

Flowery Branch Chiropractic – 4875 Hog Mountain Road, Flowery Branch, Ga 30542

Informed Consent for Examination/Treatment

I understand that neither chiropractic nor medical treatment is an exact science and that treatment involves utilization of best practices and sound judgement based on training and clinical experience. An undesirable result does not necessarily indicate judgement errors. No guarantee of result can be made or expected rather I wish to rely on the doctor to recommend and choose the best course of treatment based upon facts known in my best interest.

I understand there are certain degrees of risk associated with chiropractic and physical therapeutic modalities, which rarely includes, but is not limited to, fractures, disc injuries, strains/sprains, stroke or other musculoskeletal conditions and am willing to accept and consent to the risk associated with the care I am about to receive.

I have had the opportunity to ask questions about my case and by signing below I agree and intend this consent to cover all procedures prescribed for my condition or any future conditions for which I seek treatment/care.

By signing below, I hereby consent to the examination and treatment on myself, or my dependent, by the licensed Doctor of Chiropractic employed/engaged in this practice.

Female patients: *To the best of my knowledge, I'm not pregnant or suspected. Date of last menstrual period _____.*

Financial Policy

It is our office policy that all services are charged directly to you, the patient, and that you are ultimately responsible for all payments regardless of insurance assignment.

Patients with Insurance: We are happy to extend the courtesy of filing your insurance claims for you. Co-pays and deductibles are expected at the time of service or end of the same week; if the balance exceeds $150 before payment, care may be suspended. We work very hard to stay on top of the maximum's allowed; ultimate responsibility is yours for services rendered. I authorize release of my medical records for the purpose of processing claim payment(s).

Patients without Insurance: Payments for services are expected at the time of service, or the previously agreed to interval. Outstanding balances beyond $150 may result in suspension of service until balances are resolved; legitimate financial hardships are handled individually through consultation with our Billing Department.

ALL Patients: Returned checks or balances due over 30 days (excluding Personal Injury or Workman Compensation cases) may incur additional collection/service fees.

Signing below is acknowledgement and agreement to the above listed policy.

Privacy Practices Pursuant to HIPAA/Consent for Use of Health Information

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State and Federal Law.

A full copy of this office's HIPAA Compliance Manual is available upon request.

_____ _____

Patient's Name Signature

_____ _____

Date Relationship/Authority to Patient

_____

Witness