

PATIENT HISTORY

Date of Birth _____ Age _____ Social Security # _____
 Last _____ First _____ Middle Initial _____
 Address _____ City _____ ST _____ Zip _____
 Phone (H) _____ (W) _____ (C) _____
 Email _____ May we send you our online newsletter? yes no
 Your Occupation _____ Employer _____
 Spouse's Name _____ Spouse DOB _____ Spouse SSN: _____
 Have you been to another doctor for this problem? yes no Who/Where? _____
 Who may we thank for referring you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____
 Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time
 What makes the symptoms increase? _____ What relieves the symptoms? _____
 Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate
 Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%
 Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____
 Please list all previous treatments for this condition (give doctor's name and dates if possible) _____
 Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____
 Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time
 What makes the symptoms increase? _____ What relieves the symptoms? _____
 Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate
 Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%
 Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____
 Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

Do you smoke? yes no If yes, how many packs per week? _____
 Have you ever smoked in the past? yes no If yes, when did you quit? _____
 Do you take birth control? yes no Have you ever taken birth control in the past? yes no
 Do you consume alcohol? yes no If yes, how many drinks per week? _____
 Do you consume caffeine? yes no If yes, how many drinks per day? _____
 Do you exercise? yes no If yes, how many times per week and what type? _____
 Do you have a high stress level? yes no If yes, list reasons: _____

Please list any medications or vitamins you are currently taking:

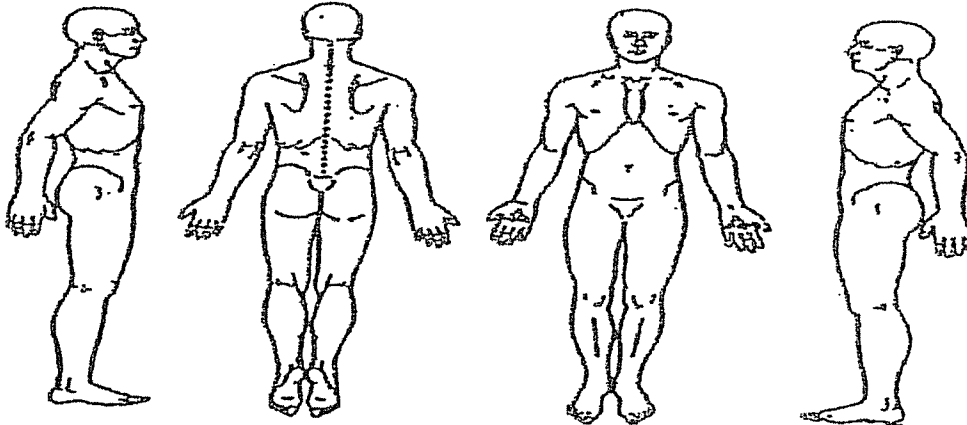
PATIENT SIGNATURE _____ DATE _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?
 Excellent Very Good Good Fair Poor

17. What type of exercise do you do?
 Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:
 Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes
if yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

INFORMED CONSENT FORM

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- | | | |
|--|--|---|
| <input type="checkbox"/> spinal manipulative therapy | <input type="checkbox"/> palpation | <input type="checkbox"/> vital signs |
| <input type="checkbox"/> range of motion testing | <input type="checkbox"/> orthopedic testing | <input type="checkbox"/> basic neurological testing |
| <input type="checkbox"/> muscle strength testing | <input type="checkbox"/> postural analysis | <input type="checkbox"/> Electrical Stim |
| <input type="checkbox"/> ultrasound | <input type="checkbox"/> hot/cold therapy | |
| <input type="checkbox"/> radiographic studies | <input type="checkbox"/> mechanical traction | |
| <input type="checkbox"/> Other (please explain) | | |
-
-
-

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Regina Syed and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature

Signature of Parent or Guardian
(if a minor)

FINANCIAL AGREEMENT

Thank you for trusting Pain & Injury Center of North Fulton to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records. I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Insurance

Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies.

We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

Medicare

We participate in Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered. We may ask you to sign an Advanced Beneficiary Notice, which lists our fee and notifies you of your financial responsibility for certain medical services.

Non-Participating Providers

Not all providers in this office participate with your plan. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage.

Continued on reverse

Patient Responsibility for Payment

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your service. Patient due balances noted on your monthly statement are due within 30 days of receipt. Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact non-custodial parent on behalf of the custodial parent.

Deposits

New patients without insurance, or if insurance co-payment and coverage cannot be verified, are required to a deposit on or before the first date service. If insurance payment results in a credit balance, it will be refunded to you within 30 days.

Payment Options

We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must make payment arrangements. We offer uninsured patients a discount for payment of office visit by cash, check, or credit card received on the date of service. Discount does not apply to lab or supply charges. Accounts with a patient due balance outstanding over

90 days will be charge finance charges of 18%.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which may affect your credit. You must contact our collection analyst to discuss payment arrangements. Referral to a collection agency, or naming Pain & Injury Center of North Fulton in a bankruptcy filing, you will be charged a processing fee and any applicable legal fees.

NSF checks will result in a \$25 processing fee.

Missed appointment fee

If you fail to contact the office with 24 hours of your missed appointment you will be charged a \$35.00 no show fee.

Patient Signature _____

Printed Name _____

Date _____

Parent/Guardian Signature _____

Printed Name _____

Pain & Injury Center of North Fulton
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