GEORGIA
CHIROPRACTIC & MASSAGE

New Patient Intake

Legal First Name: _____ Legal Last Name: _____ Preferred Name: _____

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

Date of Birth: _____ Cell / Home Phone:_____ Work Phone:_____

Email:_____ Consent to email appointment reminders & office updates : □ Yes □ No

Your Employer:_____ Occupation:_____

Marital Status:

□ Married Spouse's Name:_____
□ Single
□ Divorced
□ Widowed

Number of Children:_____ Ages:_____

How did you hear about us?

□ Friend who is a patient _____
□ Internet Search □ Event
□ Facebook □ Instagram
□ Drive By
□ Other:_____

1. **Reason for Chiropractic Care**:_____

2. **Is your condition the result of an accident or injury?**

□ N/A □ Work □ Auto □ Other_____

3. **Onset**: When did you first notice your symptoms?

_____

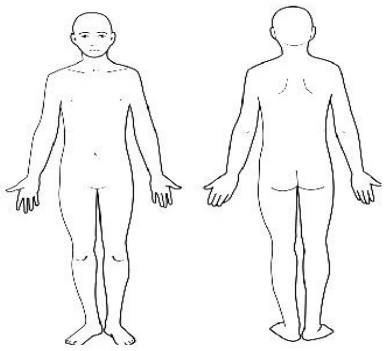
4. **Quality of Symptoms**: What does it feel like?

□ Numbness
□ Tingling
□ Stiffness
□ Dull
□ Aching
□ Cramping
□ Nagging
□ Sharp
□ Burning
□ Shooting
□ Throbbing
□ Stabbing
□ Other _____

5. **Intensity**: How extreme are your symptoms?

1 5 10
□ - □ - □ - □ - □ - □ - □ - □ - □ - □
Absent Painful Agonizing

6. **Location**: Where does it hurt?
X = current condition O= Past condition



7. **Duration/Timing**: When and how often do you feel it? □ Constant □ Sometimes

Worse in the: □ Morning □ Evening

Better in the: □ Morning □ Evening

8. **Radiating**: Does the pain radiate, shoot, or travel? Where to?

_____

9. **Aggravating/Relieving Factors**:

What worsens the problem?

_____

What lessens the problem?

_____

10. **Prior Interventions**: What have you done to relieve the symptoms?

□ Medication □ Surgery □ Ice/Heat Acupuncture □ Homeopathic Remedies □ Chiropractic
□ Physical Therapy □ Massage □ Stretching/Exercise □ Other _____

11. **What else should the doctor know about your condition**? _____

12. **Review of Systems**: Chiropractic care focuses on the integrity of your nervous system which controls and regulates you entire body. Please check beside any condition that you have NOW or had in the PAST.

Musculoskeletal
□ N/A
□ Osteoporosis □ Arthritis
□ Back Problems □ Scoliosis
□ Hip Disorders □ Neck Pain
□ Knee Injuries □ Leg Pain
□ Poor Posture □ Arm Pain
□ Shoulder Pain □ TMJ

Neurological
□ N/A
□ Anxiety
□ Depression
□ Headache
□ Dizziness
□ Pins/Needles
□ Numbness

Integumentary
□ N/A
□ Skin Cancer
□ Psoriasis
□ Eczema
□ Acne
□ Hair Loss
□ Rash

Genitourinary
□ N/A
□ Kidney Stones
□ Infertility
□ Kidney Dysfunction
□ Prostate Problems
□ Erectile Dysfunction
□ PMS Symptoms

Digestive
□ N/A
□ Anorexia/Bulimia
□ Ulcer
□ Food Sensitivities
□ Heartburn
□ Constipation or Diarrhea
□ Ulcerative Colitis

Endocrine
□ N/A
□ Thyroid Issues
□ Immune Disorders
□ Hypoglycemia
□ Frequent Infection
□ Swollen Glands
□ Low Energy

Sensory
□ N/A
□ Blurred Vision
□ Ringing in the ears
□ Hearing Loss
□ Chronic Ear Infections
□ Loss of Smell
□ Loss of Taste

Constitutional
□ N/A
□ Fainting
□ Low Libido
□ Poor Appetite
□ Fatigue
□ Sudden Weight Change
□ Weakness

Cardiovascular
□ N/A
□ High Blood Pressure
□ Low Blood Pressure
□ High Cholesterol
□ Poor Circulation
□ Angina
□ Excessive Burning

Respiratory
□ N/A
□ Asthma
□ Apnea
□ Emphysema
□ Hay Fever
□ Shortness of Breath
□ Pneumonia

Personal History: Identify YOUR past health history, including accidents, injuries, illnesses, and treatments.

14. **Illnesses**

□ Aids □Alcoholism □ Allergies □ Arteriosclerosis □ Cancer □ Diabetes □ Epilepsy □ Heart Disease
□ Hepatitis □ Multiple Sclerosis □ Mumps/Polio □ STD □ Stroke □ Ulcer □ Other:_____

15. **Surgery**

□ Appendectomy □ Bypass Surgery □ Cancer □ Cosmetic Surgery □ Elective Surgery:_____
□ Eye Surgery □ Hysterectomy □ Pacemaker □ Spine □Tonsillectomy □ Other: _____

16. **Treatments:** Check the ones you are receiving now or have in the past received.

□ Acupuncture □ Antibiotics □ Birth Control Pills □ Blood Transfusions □ C hemotherapy □ Chiropractic Care
□ Dialysis □ Herbs □ Homeopathy □ Hormone Replacement □ Inhaler □ Massage Therapy □ Physical Therapy
□ Nutritional Supplements _____□ Medications (list) _____

17. **Family History** Please give the history of your immediate family members

Relative	State of Health Good/ Poor / NA			Illnesses	Relative	State of Health Good/ Poor / NA			Illnesses
Mother	□	□	□	_____	Sister	□	□	□	_____
Father	□	□	□	_____	Brother	□	□	□	_____

18. **Are there any other hereditary health issues that you know about?**_____

Females: Is it possible that you are pregnant? □ Yes □ No First day of last cycle: _____

AUTHORIZATION AND ASSIGNMENT
AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his/ her staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/ her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

I authorize the following health care professional, medical facility, medical records service, employer, family member, etc. to receive information regarding my entire medical record, treatment records, and diagnostic records:

Person/Organization to Release Information:_____ Relationship: _____

Person/Organization to Release Information:_____ Relationship: _____

Person/Organization to Release Information:_____ Relationship: _____

Disability and Worker's Compensation Claim Notification Form

We at Georgia Chiropractic and Massage (GACM) understand that you have your choice of medical providers, and are grateful that you have chosen us. As a patient of GACM, it is our mission to provide you treatments that will assist you in getting back to a better quality of life. It is our position that while receiving treatments at the office, the ability to maintain your daily routine as much as possible can be beneficial to your overall health and recovery. However, depending on the individual circumstances, we understand that this might not be possible for everyone despite the quality of treatment you are receiving.

At some point you may feel the need to apply for temporary or permanent disability benefits, or file a worker's compensation claim. By signing you understand and agree to the following:

1. *GACM will not get involved in any disability or worker's compensation claims that you may file as a result of your condition in which you are receiving treatment.*
2. *GACM will provide copies of your records to any third-party, after receiving a HIPAA authorization, signed by you, providing the necessary information on where to send the records.*
3. *GACM, including any of its Doctors and staff, will not complete any disability or worker's compensation packets and/or information on your behalf, outside of providing copies of your records.*

You or your legal representative agree to these terms with the knowledge that you have the right to file a worker's compensation claim or apply for and obtain disability benefits on your behalf; and that there are other practitioners and practices who provide similar services and will assist with such claims, and you voluntarily choose not to seek treatment from those other practitioners or practices.

TERMS OF ACCEPTANCE

I have read, or have had read to me the Terms of Acceptance, Patient Informed Consent, Healthcare Authorization Form, Right to Revoke Authorization Form, Insurance Disclaimer, Beneficiary Agreement, Notice of Privacy Practices for Protected Health Information, and the Disability and Worker's Compensation Claim Notification. I have also had the opportunity to ask questions about its content and by signing this authorization I agree to the named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Authorization: (If Patient is under 18 years of age; the person signing below must be a parent or legal guardian with authority to act on behalf of named applicant)

Signature: _____ Date _____

First Name (OF SIGNER): _____ Last Name (OF SIGNER): _____ Date of Birth (OF SIGNER): _____

Description of Authority to act on patient behalf: _____ Social Security (last 4 only) -_____