Confidential Health Information Questionnaire

Welcome to our clinic. This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need help please don't hesitate to ask!

Name: ____
Last First MI

Email address: Personal:________________________ Work:________________________

Mailing Address: ____

____

Phone # (Home)____________ (Work)____________ (Cell) ____________
Can we call you at work? ❑ Yes ❑ No Please check your contact preference: ❑ Home ❑ Work ❑ Cell

Date of Birth: _____ /_____ /_____ Sex: ❑ Male ❑ Female SS#: ________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor
Race: ❑Caucasian ❑African American ❑Asian ❑Native American ❑Latin American ❑Other_______
Ethnicity: ❑Hispanic ❑Latino ❑Non-Hispanic/Non-Latino ❑Decline to Answer
Language: ❑English ❑Spanish ❑Indian ❑Japanese ❑Chinese ❑Korean ❑French ❑German ❑Russian

Occupation:______________________ Employer: ______________________

Spouse Occupation:______________________ Spouse Employer: ______________________

How did you hear about our practice? ______________________________

Emergency contact: Name: ____________ Relation: ____________ Phone #: ____________

Names of children/ages:____

Financial Information:

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ________________

Are you the policy holder? ❑Yes ❑No If no, who is the policy holder: ❑Spouse ❑Parent ❑Employer ❑Other

Policy Holder's Name: ________________ Policy Holder's Date of Birth: ____________

Policy Holder's SS#: ____________ Policy Holder's Employer: ________________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ________________

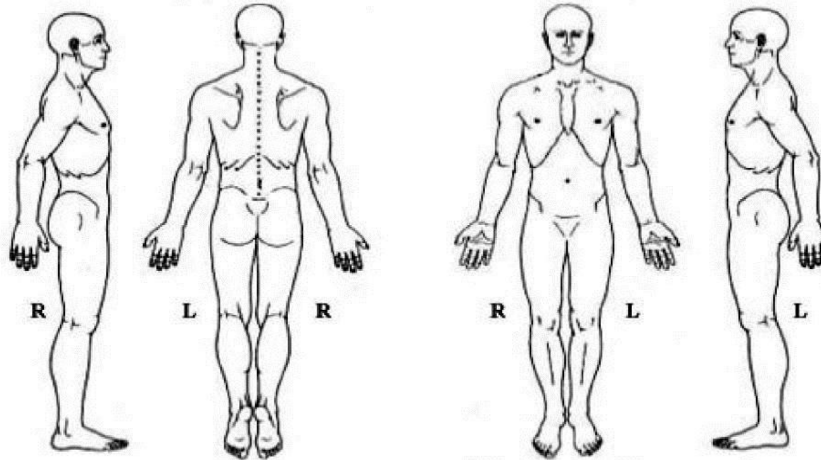
PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) AND IDENTIFICATION

Our Philosophy:

You deserve to be healthy and our goal is for you to feel better than you have in years! When you were born, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, life is stressful. Emotional and physical stress, accidents, and other challenges can seriously impact your health. Today we will find out what is causing your health problems and determine a care plan that restores your health, so you can live the quality of life you deserve.

Current Health Condition:

Please shade in the area of your pain or symptoms in the image below.



What is your chief complaint / main health concerns for your visit today?

____

Please briefly describe any other complaints you would like for us to also address:

____

How long have you had the **main** health concern/problem? ❑ ____Days ❑____Weeks ❑____Months ❑ ____Years

Under what circumstances did the pain begin?

❑ Accident at work ❑ Accident at home ❑ At work but not incident ❑ Pain just began, no reason
❑ Following illness ❑ Following surgery ❑Motor Vehicle Accident ❑ Repetitive stress / overuse
❑ Following exercise/sports ❑Other_______________________________________

Where is the problem located? ❑ Head ❑ Neck ❑ Shoulder ❑Elbow ❑Wrist/Hand ❑ Upper Back ❑ Middle Back
❑Lower Back ❑ Hip ❑ Knee ❑ Foot/Ankle ❑Other:___________________________

How would you describe your pain? ❑Aching ❑Stabbing ❑Shooting ❑Numb ❑Throbbing ❑Sharp ❑Burning

Your AVERAGE pain score is: (circle one)

0-----------1-----------2-----------3-----------4-----------5-----------6-----------7-----------8-----------9----------10

None mild moderate severe very severe WORST

When your pain is at its WORST your pain score is: (circle one)

0-----------1-----------2-----------3-----------4-----------5-----------6-----------7-----------8-----------9----------10

None mild moderate severe very severe WORST

When do your symptoms occur? ❑Constantly ❑ At Rest ❑With activity ❑ Other______________________________

Which statement best describes your pain?

❑Always Present, always the same intensity ❑ Usually Present, but have short periods without pain
❑ Always Present, Intensity varies ❑ Often Present, but I am pain free for most of the day

Do any of the following make your pain feel worse? (Check all that apply) ❑Bending ❑Sitting ❑Twisting
❑Standing ❑Walking ❑Lifting ❑Physical Activity ❑Coughing/Sneezing ❑Sexual Activity
❑ Lying Flat ❑ Can't find a comfortable position ❑ Other:______________________________________

Does any of the following make your pain better? (Check all that apply) ❑Relaxation ❑Stretching ❑ Sitting
❑ Standing ❑Walking ❑ Lying down ❑ Medication ❑ Ice ❑ Heat ❑ Nothing makes it feel better

Does this pain radiate anywhere? ❑ Yes ❑No Where? ____

Please circle YES or NO for the following questions and answer appropriately:

Have you seen any other Doctors for the condition? What treatment was rendered? NO YES

____

____

Have you tried any medications such as anti-inflammatory or Prescription Painkillers for your complaint? If yes, what kind of medication? what side effects? NO YES

____

Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
If yes: When? For how long? What kind?

____

Have you previously had any recent imaging (MRI, CT, Xray) taken within the last 12 months? NO YES
If yes:

Type of Imaging:_____________________________________Date of Exam:______________________________
Facility Performed:___________________________________Phone:____________________________________

Medications you are currently taking (**Include over the counter, herbal, and natural remedies with dosage and frequency**):

_____________________________ _______________________________ ___________________________

_____________________________ _______________________________ ___________________________

Please list any general or medication **allergies** and your reaction to them:

Allergy	Reaction

Who is your primary care physician? (doctor and/or practice) ____

Please list any surgical history:

_____________________________ _______________________________ ___________________________

_____________________________ _______________________________ ___________________________

Other Present Medical Signs or Symptoms

Constitutional Symptoms
- ☐ No symptoms
- ☐ Chills/Fever
- ☐ Loss of appetite
- ☐ Poor sleep/ insomnia
- ☐ Night sweats
- ☐ Recent weight loss
- ☐ Recent weight gain

Eyes, Ears, Nose and Throat
- ☐ No symptoms
- ☐ Earache R or L
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Sinus Trouble
- ☐ Difficulty swallowing

Cardiovascular
- ☐ No symptoms
- ☐ Chest Discomfort
- ☐ Chest Pain
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Leg Cramps at Rest
- ☐ Leg Cramps on Exertion
- ☐ Leg Swelling

Genitourinary
- ☐ No symptoms
- ☐ Frequency
- ☐ Incontinence
- ☐ Urgency

Musculoskeletal
- ☐ No symptoms

Neck
- ☐ Pain
- ☐ Stiffness

Back
- ☐ Pain
- ☐ Stiffness
- ☐ Tenderness

Joints:(circle) hips, knees, feet, shoulder, elbow, hands
- ☐ Aching
- ☐ Arthritis
- ☐ Limitation of joint movement
- ☐ Redness
- ☐ Morning Stiffness
- ☐ Swelling
- ☐ Tenderness

Muscles
- ☐ Aches
- ☐ Weakness

Neurological
- ☐ No symptoms
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis/Paresis
- ☐ Disorientation
- ☐ Vertigo/spinning
- ☐ Unsteadiness
- ☐ Dizziness

Psychiatric
- ☐ No symptoms
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Stressed
- ☐ Change in behavior

Endocrine
- ☐ No symptoms
- ☐ Cold intolerance
- ☐ Excessive Sweating
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Hot flashes

Gastrointestinal
- ☐ No symptoms
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Peptic Ulcers
- ☐ Indigestion
- ☐ Nausea
- Vomiting

Pulmonary
- ☐ No symptoms
- ☐ Cough
- ☐ Asthma
- ☐ Pain with exertion

Please list any other signs or symptoms you are having that are not listed:

____

____

____

____

Past Medical History

Neurological:
- ☐ Migraines / Headaches
- ☐ TIA/Stroke
- ☐ Peripheral Neuropathy
- ☐ Concussion
- ☐ Spinal Cord Injury
- ☐ Multiple Sclerosis

Musculoskeletal:
- ☐ Shoulder injury
- ☐ Elbow injury
- ☐ Carpal Tunnel
- ☐ Knee injury
- ☐ Hip injury
- ☐ Joint Replacements

Renal:
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Dialysis

Endocrine:
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Thyroid disease
- ☐ Cushing's Disease
- ☐ Grave's Disease
- ☐ Addison's Disease

Urinary & Reproductive:
- ☐ Incontinence
- ☐ Enlarged Prostate
- ☐ STD's: __________
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Interstital Cystitis
- ☐ Other:_____________

Heme/Oncology:
- ☐ Cancer: _________________

Cardiovascular:
- ☐ High Blood Pressure/HTN
- ☐ Vascular Disease
- ☐ Pacemaker

Respiratory:
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Pulmonary Hypertension
- ☐ Tuberculosis

Gastrointestinal:
- ☐ GERD
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Gall Bladder
- ☐ Gluten Sensitivity

Rheumatology:
- ☐ Osteoarthritis: Location:__________
- ☐ Rheumatoid arthritis
- ☐ Arthritis (unknown)
- ☐ Osteoporosis
- ☐ Gout
- ☐ Ankylosing spondylitis
- ☐ Other: ___________

Please list any other signs or symptoms you are having that are not listed:

____

____

____

Family & Social History

Is there a family history of?	Disc Disease	Heart Disease	Arthritis	Cancer	Diabetes
Father's Family	❑	❑	❑	❑	❑
Mother's Family	❑	❑	❑	❑	❑

Females only: Are you pregnant, planning a pregnancy or nursing a child? ❑ Yes ❑ No

Tell us about your home environment? ❑ Live Alone ❑ With Spouse ❑ With Children ❑ With Relatives
❑ With Friends/Roommates ❑ Assisted Living Home ❑ Care-taker

Do you exercise?: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Describe your sleep habits per night: ❑ Constant ❑ Interrupted ❑ 8+ Hours ❑ 6-7 Hours ❑ 5 or less

Do your work activities mostly involve?: ❑ Sitting ❑ Standing ❑ Computers ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following?:

Have you ever smoked? ❑ No ❑ Yes ❑ Cigar ❑ Pipe ❑ Cigarettes If yes, _______/day __________ # of years

Do you drink caffeinated beverages? ❑ Coffee ❑ Teas ❑ Sodas ❑ Energy Drinks regularly? __________/day

Do you use illegal drugs? ❑ No ❑ Yes If yes, what type? ____

Health Goals

On your second visit we will review the results of your evaluation and discuss a treatment plan that meets your goals and helps you to be as healthy as possible.

As a result of my treatment in this office, I would like to... (please check all that apply)
❑ Feel better quickly ❑ Have a healthier body by keeping my nervous system healthy
❑ Live a healthier lifestyle ❑ Live a more active lifestyle ❑Have a healthier spine

What other health goals do you have:____

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT:

I certify that the above information is true and correct to the best of my knowledge. I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. When and if any charges that may be incurred for services are not paid in full by me or provided insurance, I agree to pay any and all collection and/or attorney fees with the original balance due. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

PATIENT SIGNATURE______________________________________DATE ________________

DIRECTIONS

*******PLEASE NOTE THAT GPS DEVICES RECOGNIZE 7100 PEACHTREE DUNWOODY AS THE NORTH SPRINGS MARTA STATION. WE ARE LOCATED ON THE OPPOSITE SIDE, 500 FEET FURTHER NORTH ON PEACHTREE DUNWOODY. WE ARE A SINGLE BRICK BUILDING SEPARATE FROM THE 7000 BUILDINGS AND ACROSS THE STREET FROM 7150 ASPIRE DUNWOODY APARTMENTS.*******

FROM I-75N: TAKE 285E TO 400N. TAKE EXIT 5A (DUNWOODY) AND VEER TO THE RIGHT. AT THE FIRST INTERSECTION (PEACHTREE DUNWOODY), MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES. YOU WILL PASS THE NORTH SPRINGS MARTA STATION ON THE LEFT AT THE SECOND TRAFFIC LIGHT. PASS THE 7000 BUILDING ON THE RIGHT. 7100 PEACHTREE DUNWOODY RD WILL BE ON THE RIGHT HAND SIDE. FIND SUITE 110 ON THE LOWER LEVEL RIGHT (SOUTH) SIDE OF THE BUILDING

FROM I-285 EAST: TAKE EXIT 28 PEACHTREE DUNWOODY ROAD AND VEER TO THE RIGHT. PASS NORTHSIDE HOSPITAL AND CHILDREN'S HOSPITAL OF ATLANTA ON YOUR LEFT. CONTINUE NORTH ON PEACHTREE DUNWOODY ROAD. WE ARE LOCATED ON THE RIGHT AT 7100 IN A SINGLE BRICK BUILDING.

FROM I-285 WEST: TAKE EXIT GA 400 NORTH. TAKE EXIT 5A (DUNWOODY). AT THE FIRST INTERSECTION (PEACHTREE DUNWOODY), MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES. WE ARE LOCATED ON THE RIGHT AT 7100 IN A SINGLE BRICK BUILDING.

FROM I-85 NORTH: TAKE 85 SOUTH TO I-285 WEST. TAKE 400 NORTH EXIT. TAKE EXIT 5A (DUNWOODY) AT THE FIRST INTERSECTION (PEACHTREE DUNWOODY), MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES. YOU WILL PASS THE NORTH SPRINGS MARTA STATION ON THE LEFT AT THE SECOND TRAFFIC LIGHT. PASS THE 7000 BUILDING AND 7100 PEACHTREE DUNWOODY RD IS ALSO ON THE RIGHT.

FROM 75/85 SOUTH (DOWNTOWN): TAKE 75/85 NORTH. CONTINUE ON 85 NORTH AT THE SPLIT. TAKE GA 400 EXIT TO THE TOLL. FROM 400 NORTH, TAKE EXIT 5A TO DUNWOODY. AT THE FIRST INTERSECTION (PEACHTREE DUNWOODY), MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES TO 7100.

FROM NORTH SPRINGS MARTA STATION: CROSS AT THE LIGHT SO THAT YOU ARE ON THE OPPOSITE SIDE OF THE STREET. TURN LEFT AND CONTINUE ON PEACHTREE DUNWOODY ROAD FOR APPROXIMATELY 500 FT AND OUR OFFICE WILL BE ON YOUR RIGHT AT 7100 PEACHTREE DUNWOODY ROAD.