Patient Name: _____ **Date:** _____

WELCOME: The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

Address_____ City_____ Zip Code_____

H. Phone_____ W. Phone_____ Cell Phone_____

Email Address_____ Emergency Contact_____ Phone_____

How did you hear about us? _____ Spouse_____ Phone_____

Occupation_____ Employer_____

Sex □ M □ F Marital Status □ M □ S □ D □ W Height: _____ Weight: ____ Birth Date_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury? □ Yes □ No
Who besides yourself is responsible for your bill? □Self-Pay □Health Insurance □Medicare □Auto Insurance
Personal Health Insurance Carrier: _____ Health ID Card #:_____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ /_____/_____ Auto Insurance Carrier & Claim #: _____

What is your goal for seeking treatment? _____

Have you been under Chiropractic Care previously? _____

Please rate your levels of pain 0-10 with 10 being the worst possible score below and circle all symptoms that apply:

HEADACHE:	__0-10 Pain	Occipital		Frontal		Temporal				__Left /__Right
NECK:	__0-10 Pain	Stiff	Numb	Spasm	Weak	Achy	Dull	Sharp	Throb	__Left /__Right
SHOULDER:	__0-10 Pain	Stiff	Numb	Spasm	Weak	Achy	Dull	Sharp	Throb	__Left /__Right
MID BACK:	__0-10 Pain	Stiff	Numb	Spasm	Weak	Achy	Dull	Sharp	Throb	__Left /__Right
LOWBACK:	__0-10 Pain	Stiff	Numb	Spasm	Weak	Achy	Dull	Sharp	Throb	__Left /__Right
HIP:	__0-10 Pain	Stiff	Numb	Spasm	Weak	Achy	Dull	Sharp	Throb	__Left /__Right
LEG/KNEE:	__0-10 Pain	Stiff	Numb	Spasm	Weak	Achy	Dull	Sharp	Throb	__Left /__Right
ARM/HAND:	__0-10 Pain	Stiff	Numb	Spasm	Weak	Achy	Dull	Sharp	Throb	__Left /__Right
FEET/TOES	__0-10 Pain	Stiff	Numb	Spasm	Weak	Achy	Dull	Sharp	Throb	__Left /__Right

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____
_____
_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____
_____
_____

Do you have a family history of (Please indicate all that apply): □ Cancer □ Strokes/TIA's □ Headaches
□ Heart disease □ Neurological diseases □ Adopted/Unknown □ Psychiatric disease □ Diabetes

Are you allergic to any medications/foods/other_____

Do you smoke □ Yes □ No Drink alcohol □ Yes □ No Recreational drugs □ Yes □ No

Have you had any of the following **respiratory (lung-related)** issues?
□ Asthma □ COPD □ Emphysema □ Coughing up blood □ Shortness of breath □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart murmur □ Claudication (leg pain or achiness) □ Heart problems □ Orthopnea (difficulty breathing while lying)
□ Palpitations □ Shortness of breath □ Swelling of legs □ Ulcers □ Varicose veins □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Dizziness □ Facial weakness □ History of seizures □ Headaches □ Limb weakness □ Loss of consciousness
□ Loss of memory □ Numbness □ Seizures □ Strokes □ Sleep disturbance □ Slurred speech □ Stress □ Tremors
□ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Cold intolerance □ Diabetes □ Excessive appetite □ Excessive hunger □ Excessive thirst □ Frequent urination
□ Goiter □ Hair loss □ Heat intolerance □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (cannot control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Abdominal pain □ Belching □ Hiatal hernia □ Constipation
□ Heartburn □ Diarrhea □ Hemorrhoids □ Bloody or black tarry stools □ Vomiting blood □ Indigestion □ Jaundice
□ Rectal bleeding □ Vomiting □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Bleeding □ Blood clotting □ Blood transfusions □ Bruises easily □ Fatigue □ Hemophilia
□ Lymph node swelling □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Changes in nail texture □ Changes in skin color □ Hair growth □ Hair loss □ Hives □ Itching □ Rash □ Psoriatic disorders □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ None of the above

AUTHORIZATION FOR RELEASE OF INFORMATION:
I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:
I authorize payment of medical benefits to Akridge Chiropractic Inc. P.S. for services rendered to me.

REIMBURSEMENT POLICY:
We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company, and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:
I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins or terminate my care as a patient if, during treatment, I am not following the treatment plan for my condition or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Patient or Guardian Signature _____ Date_____