CHIROPRACTIC
WORKS

101 Cedar Rock Trace
Athens, GA 30605
P# 706-548-8984
www.chiropracticworks.com

Welcome to our office! We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and only released with your consent. These forms should be completed in **ink** or typed only (no pencil), and you may bring them with you on the day of your visit. Please make sure all blanks are filled in.

These are a few items that you will need on the day of your visit:

- **Insurance Card** (if you have insurance) and **Picture ID**
- **Co-Payment, Co-insurances** and **Deductible** (if you have one), and payment for any balances due.
- A list of the prescription(s) and over the counter **medications** you are currently taking, including any herbs or vitamins. Please include the dosage.
- Any **x-rays or MRI's** from a previous Chiropractor and your Primary Care Physician/Family Doctor, which may be related to your reason for visit. Please bring them with you to your office visit and give to the Front Desk upon arrival.

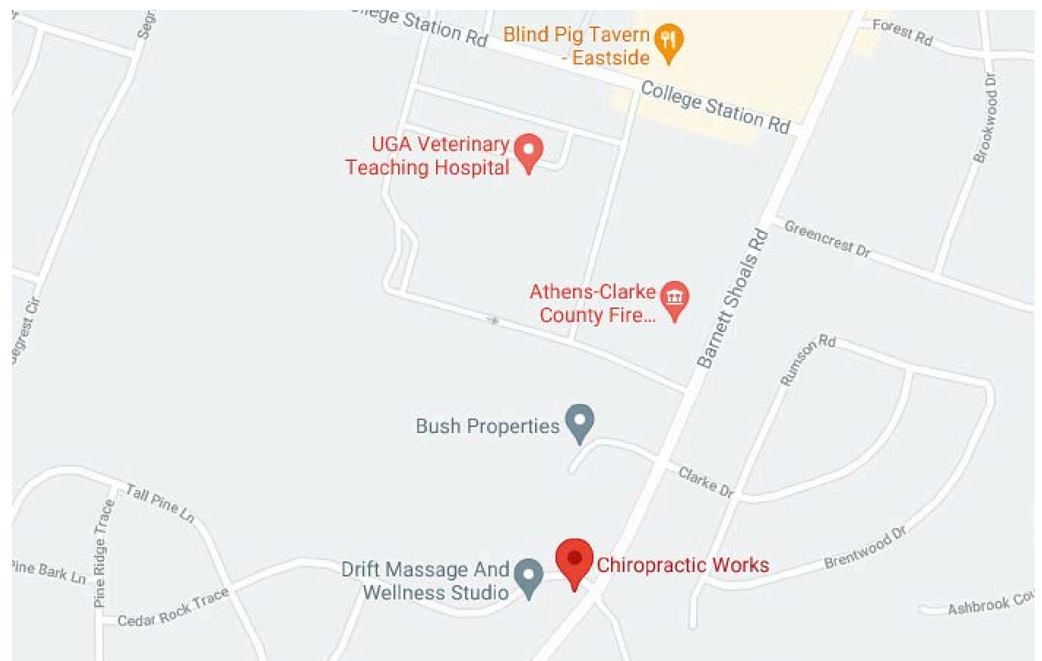
Co-Payments/Deductibles (if you have one), and Co-insurances are due at time of visit.
It is the patient's responsibility to know what their insurance covers.
If you are a **student at UGA** and using student insurance, it is ***your responsibility to obtain a referral from the Student Health Center prior*** to coming in for your first visit. **We** are not responsible if your **benefits do not pay** due to the **lack of a referral.**

Please arrive 10 to 15 minutes early for your first appointment in order for us to complete your check in process.

As always, we do everything we can to better serve your needs in the most efficient and professional manner.
If you have any questions or concerns, please do not hesitate to contact us at (706) 548-8984.

To avoid "no-show" fees, please call our office 24 hours in advance if you are unable to keep, or need to reschedule your appointment. A broken appointment is a loss to everyone.

Thank you for allowing us to be part of your healthcare team!!



Chart#____________________

Chiropractic Works

101 Cedar Rock Trace ◊ Athens, GA 30605 ◊ 706-548-8984

Name ____Date______________________

DOB: _____/______/_______ SS#_______-_______-___________ Email ____

Address ____

Phone: (H) ____________________ (C) _______________________ (W) ______________________

Employer___________________________ Occupation & Job Description____

Emergency Contact Name ____________________________________P#_____________________Relationship___________

Please list current medications & dosage. If you aren't taking any, please write none currently.

____

____

Any Allergies? □ No □ Yes (If yes, please list & reaction) ____

Any Surgeries? □ No □ Yes (If yes, please list) ____

____

Pacemaker? Yes or No **Hardware? Yes or No** **Implants? Yes or No** **Females: IUD? Yes or No**

Past Medical History: (mark all that apply) □Car accident (date_________) □Heart attack □Congestive heart □A-Fib □Diabetes □High blood pressure □Cholesterol □Stroke □Cancer □Asthma □COPD □Ulcer □Thyroid □AIDS □TB □other________________

Childhood Illnesses: □Chickenpox □Measles □Mumps □Whooping Cough □Asthma □RSV □Other ________________

Family History: Please mark the condition(s) related to your parents □Adopted/unknown

Mother : □Healthy □Stroke □Cancer □Diabetes □High Blood Pressure □Deceased □Unknown

Father : □Healthy □Stroke □Cancer □Diabetes □High Blood Pressure □Deceased □Unknown

Caffeine(coffee/tea/soda) ______cups/day **Alcohol** ______/day ______/week **other substances** _______________

Smoking Status □daily (circle: heavy or light?) □former □never

Review of Systems: (mark all that apply)

GENERAL: □weakness □fatigue/lethargy □trouble sleeping □weight gain □weight loss □increased appetite □ decreased appetite

SKIN: □rash □sore □itching □dry □changes in hair/nails

HEENT: □headache □head injury □dizzy □lightheaded □vision changes □tearing □tinnitus □vertigo □sinus trouble

CARDIOVASCULAR: □chest pain/discomfort □palpitations □edema

RESPIRATORY: □cough □sputum □hemoptysis □dyspnea □wheezing □sleep apnea

GI: □trouble swallowing □heartburn □nausea □constipation □diarrhea □abdominal pain □food intolerance □Crohn's

URINARY: □polyuria □nocturia □urgency □hematuria □infections □stones □incontinence □dribbling

PERIP.VASC.: □leg cramps □varicose veins

MSK: □neck pain □back pain □muscle pain □joint pain □stiffness □swelling □tenderness □redness □limited range of motion

NEUROLOGICAL: □fainting □blackouts □seizures □restless legs □weakness □paralysis □numbness □tingling □tremors

ENDOCRINE: □heat intolerance □cold intolerance □excessive sweating □excessive thirst □excessive hunger □change in glove/hat/shoe size

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Additional Comments:

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NAME____ DATE_______________

Explain your health concern in detail:

____

____

____

Please identify the other health care providers you have seen, treatments, and results:

____

____

____

Any other health concerns you wish for this office to know about?

____

____

Sleeping Habits (include how many hours/quality):

____

____

Activity Level:

____

____

Past Medical History: (Circle all that apply)

Measles
Mumps
Chicken Pox
Trauma
Oculo-motor Problems
Learning Difficulties
Fever
Cravings
Diarrhea
Diabetes
Weight Management
Seizures

Ear Infections
Allergies
Asthma
Bed Wetting
Walking Difficulties
Colic
Anxiousness
Food Sensitivities
Influenza
Autoimmune
Lyme's Disease
Fear

Upper Respiratory Infection
Bronchitis
Eczema
Motion Sickness
Rashes
Balance
Clumsy
Constipation
Endocrine
Cancer
Depression
OCD

Please discuss how circled items were managed (include treatments and outcomes):

____

____

Please describe your main reason to participate in this consultation:

____

____

____

Family History:
Please describe in detail your family history. Indicate if parents or siblings experience autoimmune disorder, diabetes, cancer, heart disease, stroke, heart attack, angina, dementia, depression, gastro-intestinal dysfunction, endocrine dysfunction, mental illness, anxiety…please feel free to add any other family health issues:

____

____

____

____

Were you ever involved in a trauma? ☐ No ☐Yes Please describe:

____

____

Did you participate in sports as a youth? ☐No ☐Yes

i.e. football, soccer, gymnastics, baseball, basketball, cheerleading, martial arts, etc…)

Sports: ____

Have you ever been involved in a car accident? ☐No ☐Yes Please describe:

____

____

Have you ever been seen for an emergency other than a trauma? ☐No ☐Yes Please describe:

____

____

Diet: Describe your diet over the last 24 hours:

Breakfast:____

Lunch:____

Dinner:____

____

Menstration (Female patients)? ☐No ☐Yes Age: ________________

Signature of person completing this document: __________________________________
Print Name: ____
Date: ____________________________