

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**.

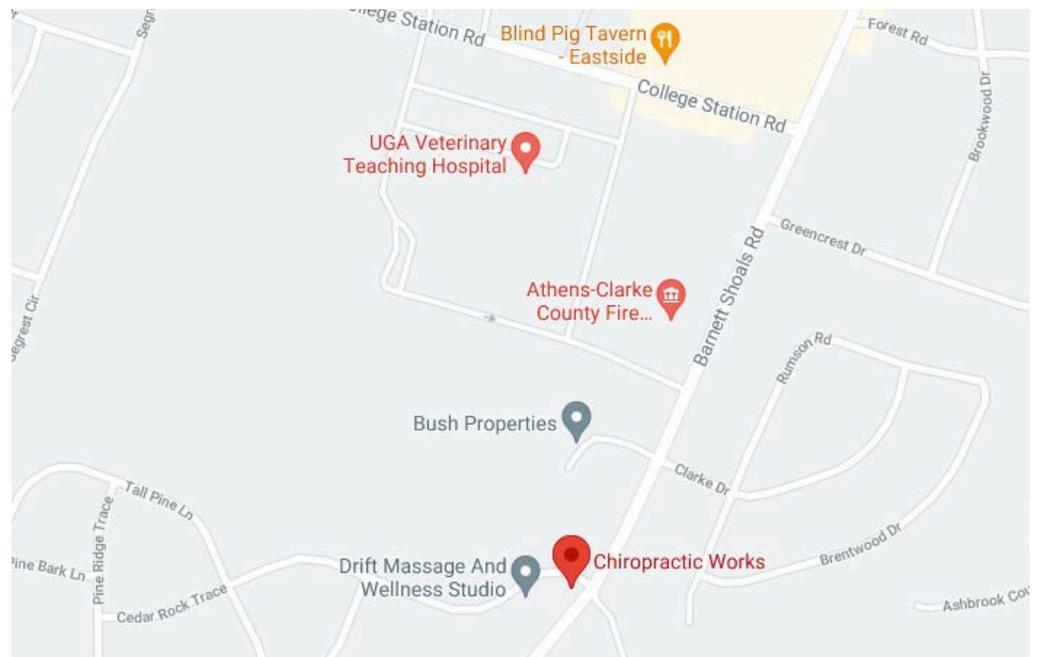
Please arrive 10 to 15 minutes early for your first appointment in order for us to complete your check in process.

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!!*



**Chiropractic Works****101 Cedar Rock Trace ♦ Athens, GA 30605 ♦ 706-548-8984**

Name \_\_\_\_\_ Date \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation &amp; Job Description \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ P# \_\_\_\_\_ Relationship \_\_\_\_\_

Please list current medications &amp; 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/unknownMother :  Healthy  Stroke  Cancer  Diabetes  High Blood Pressure  Deceased  UnknownFather :  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 appetiteSKIN:  rash  sore  itching  dry  changes in hair/nailsHEENT:  headache  head injury  dizzy  lightheaded  vision changes  tearing  tinnitus  vertigo  sinus troubleCARDIOVASCULAR:  chest pain/discomfort  palpitations  edemaRESPIRATORY:  cough  sputum  hemoptysis  dyspnea  wheezing  sleep apneaGI:  trouble swallowing  heartburn  nausea  constipation  diarrhea  abdominal pain  food intolerance  Crohn'sURINARY:  polyuria  nocturia  urgency  hematuria  infections  stones  incontinence  dribblingPERIP.VASC.:  leg cramps  varicose veinsMSK:  neck pain  back pain  muscle pain  joint pain  stiffness  swelling  tenderness  redness  limited range of motionNEUROLOGICAL:  fainting  blackouts  seizures  restless legs  weakness  paralysis  numbness  tingling  tremorsENDOCRINE:  heat intolerance  cold intolerance  excessive sweating  excessive thirst  excessive hunger  change in glove/hat/shoe size**Additional Comments:**



101 Cedar Rock Trace  
Athens, GA 30605  
(706) 548-8984  
[www.chiropracticworks.com](http://www.chiropracticworks.com)

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	Ear Infections	Upper Respiratory Infection
Mumps	Allergies	Bronchitis
Chicken Pox	Asthma	Eczema
Trauma	Bed Wetting	Motion Sickness
Oculo-motor Problems	Walking Difficulties	Rashes
Learning Difficulties	Colic	Balance
Fever	Anxiousness	Clumsy
Cravings	Food Sensitivities	Constipation
Diarrhea	Influenza	Endocrine
Diabetes	Autoimmune	Cancer
Weight Management	Lyme's Disease	Depression
Seizures	Fear	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: \_\_\_\_\_

# Chiropractic Works/Athens Brain Training Authorization and Consent Form

\_\_\_\_\_(initials)**Patient Acknowledgement of Notice to Private Practices:** As required by the privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been offered an electronic copy of the Notice of Privacy Practices that describes how my identifiable information may be used and disclosed and how I can get access to my health information. I understand the Notice may be changed at any time as permitted by applicable law. I may obtain a current paper copy of the Notice by asking the front desk personnel for one, or I can view it via my electronic access to my electronic health record or the copy posted in the reception area. My signature below acknowledges that I have been provided access to an electronic copy and a paper copy posted in the reception area of the Notice of Privacy Practices to read.

Who can we release information to / speak to about your care?

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_(initials)**Consent to Treat:** I hereby authorize and consent to treatment-related health care services, including but not limited to: chiropractic adjustments, examinations, and various modes of manual/physical therapies, stretching, massage, therapeutic ultrasound, electric muscle stimulation, hot or cold packs, traction, decompression, and exercise. I do not expect the doctor to be able to anticipate and explain all risks and complications. Risks to treatment are very minor, including but not limited to rib fracture (rare occurrence & generally resulting from an underlying weakness of the bone), muscle & ligament sprains (rare), injury to discs, nerves spinal cord (very rare), stroke (extremely rare one in a million to one in ten million). I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels, based upon the facts known, are in my best interest. I acknowledge that I have discussed, or had the opportunity to discuss, with either the doctor or staff, the risks and benefits of undergoing treatment; I have freely decided to undergo treatment, and hereby give my full consent to treatment. The doctor may use his/her hands or a mechanical device in order to manipulate the joints. I may hear a “click or pop” similar to when a joint is “cracked” and I may feel the movement of the joint. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_(initials) **Consent for Minor:** I acknowledge that I have read and understand the above consent to treat information and authorize and give consent to the doctor(s), staff, and doctor assistants of Chiropractic Works/Athens Brain Training to treat my minor child. As of today’s date, I have the legal right to select and authorize health care service for the minor child named below. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

\_\_\_\_\_(initials)**Payment Policy Agreement abbreviated:** I understand and agree that my health/accident insurance policies are an arrangement between my insurance carrier and myself. I understand and agree that I am personally responsible for payment of all services rendered to me, and minor if applicable. I also understand that if I suspend or terminate care, any fees for services rendered will be due immediately. I hereby acknowledge that I have read and understand the full payment policy of this office and agree to abide by its guidelines.

\_\_\_\_\_(initials)**Missed appointments.** We understand things come up from time to time that may prevent you from keeping your regularly scheduled appointment. We ask that you give us notice in a reasonable amount of time prior to your appointment so that we may offer this time to another patient. If you miss appointments without reasonable notice, you may be charged a missed appointment fee of \$25. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

\_\_\_\_\_(initials) I understand that open room adjusting may be used and that if I wish to speak with the doctor or staff in private, I need to inform a staff member.

My initials next to each section and my signature below acknowledges my agreement and consent to all of the above information.

Print patient name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Today’s Date \_\_\_\_\_

Signature of patient or legal representative \_\_\_\_\_ relationship to patient \_\_\_\_\_

Would you like a paper copy of the above notices? \_\_\_\_\_ Yes \_\_\_\_\_ No.

**FOR OFFICE USE ONLY: To be completed only if Acknowledgement is not signed.** Staff Initials \_\_\_\_\_ Date \_\_\_\_\_

- 1) Was the patient given a copy of Notice of Privacy Practices either/and in print/electronic format? [ ] YES [ ] NO
- 2) Please explain why the patient was unable/refused to sign and our efforts to try to obtain signature