CHIROPRACTIC WORKS

1050 Barber Creek Dr. Bldg. 200
Watkinsville, GA 30677
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.

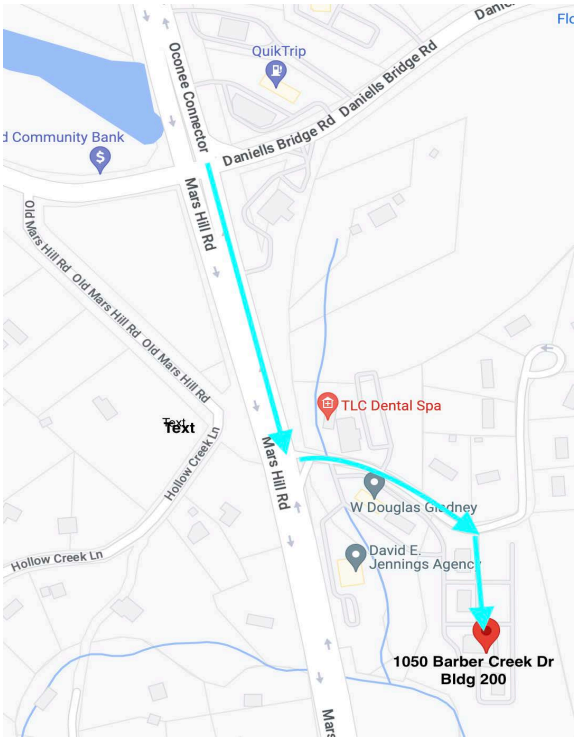
Co-Payments/Deductibles (if you have one), and Co-insurances are due at time of visit.
It is the patient's responsibility to know what their insurance covers.
If you are a **student at UGA** and using student insurance, it is ***your responsibility to obtain a referral from the Student Health Center 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

1050 Barber Creek Dr. Bldg. 200 ◊ Watkinsville, GA 30677 ◊ 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:

NECK INDEX

Patient _____ **DOB**___/___/_____ **Today's Date** ___/___/_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem

Pain Intensity
⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping
⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Reading
⓪ I can read as much as I want to with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration
⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work
⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

. Personal Care
⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting
⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving
⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation
⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches
⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time

Scored by Office Staff or Doctor ONLY

BACK INDEX

Patient _____ **DOB**___/___/_____ **Today's Date** ___/___/_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem

Pain Intensity
⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping
⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ The pain prevents me from sleeping at all.

Sitting
⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than ½ hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing
⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than ½ hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking
⓪ I have no pain while walking.
① I have some pain while walking but it does not increase with distance.
② I cannot walk for more than 1 mile without increasing pain.
③ I cannot walk for more than ½ mile without increasing pain.
④ I cannot walk for more than ¼ mile without increasing pain.
⑤ I cannot walk at all without increasing pain

Personal Care
⓪ I do not have to change my way of washing or dressing to avoid pain.
① I do not change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases pain but I manage not to change my way of doing it.
③ Washing and dressing increases pain and I find it necessary to change my way of doing it.
④ Because of pain I am unable to do some washing and dressing without help.
⑤ Because of pain I am unable to do any washing and dressing without help.

Lifting
⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling
⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms make it worse.
② I get extra pain while traveling but it does not cause me to seek alternative forms.
③ I get extra pain while traveling which causes me to seek alternative forms.
④ Pain restricts all forms of travel except those done while lying down.
⑤ Pain restricts all forms of travel.

Social Life
⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting more energetic interests (e.g. dancing, exercise).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain
⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

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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