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.

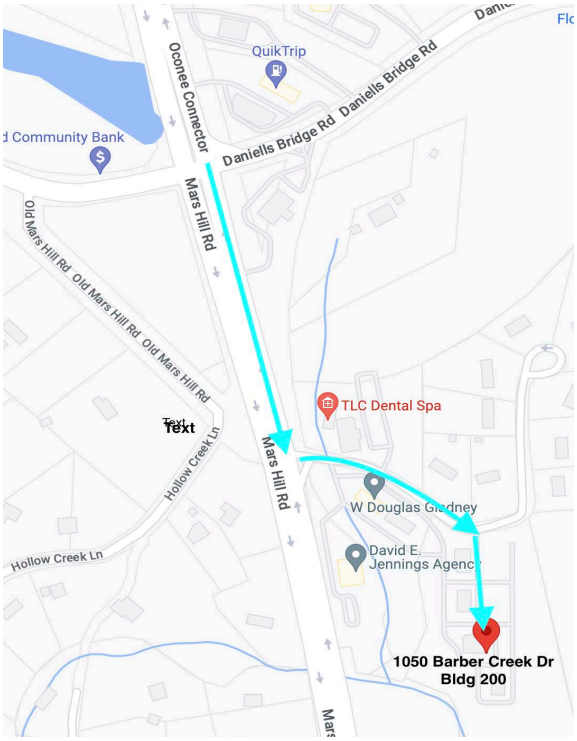
Co-Payments/Deductibles (if you have one), and Co-insurances are due at time of visit.
It is the patient's responsibility to know what their insurance covers.
If you are a **student at UGA** and using student insurance, it is ***your responsibility to obtain a referral from the Student Health Center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

---

Additional Comments:

CHIROPRACTIC WORKS

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