

CONFIDENTIAL PATIENT HISTORY

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask.

PLEASE PRINT.

Today's Date _____

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status S M W D No. of Children _____

Describe all Complaints and How and When they occurred _____

Is your condition due to an accident? Yes _____ No _____ Date of Accident _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an auto accident? Past year _____ Past 5 years _____ Over 5 years _____

Your employer _____ Occupation _____ Years of Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone _____ Your SS# _____ Driv Lic# _____

Do you have an e-mail address? _____ @ _____

Do you have health insurance where you work? Yes _____ No _____ Plan/Group# _____

Insurance Company _____ Phone# _____

Name of Spouse or Parent _____ Birthdate _____

Spouse employed by _____ Occupation _____ Years at Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone _____ Spouse SS# _____ Driv Lic# _____

Does your spouse have insurance at work? Yes _____ No _____ Plan/Group# _____

I (we) agree to pay for services rendered to the above patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the event of default of payment I further agree to pay any collection fees incurred.

Note: It is understood and agreed that the amount paid to the Chiropractic Health Center for X-rays studies, is for examination only and the x-ray negatives will remain the property of this clinic, being on file where they may be seen at any time while a patient of this clinic.

Patient's Signature _____ Date _____

Spouse or Guardian's Signature _____ Date _____

PLEASE CHECK ALL PROBLEMS THAT YOU HAVE OR HAVE HAD:

HEAD

- headaches
- dizziness

EARS

- loss of hearing
- pain
- discharge
- ringing

NOSE

- pressure
- frequent colds
- sinus
- allergies
- loss of smell

THROAT

- pain
- tonsillitis

HEART

- pain
- spasms
- palpitations
- attack

NECK

- pain
- loss of movement
- stiff
- muscle spasms
- tension

SHOULDERS

- pain
- stiff
- tension

ARMS

- pain
- numbness
- stiff
- sensation of pins & needles

MID BACK

- pain
- pain between shoulder blades
- sharp stabbing pain
- muscle spasms

LOW BACK

- pain
- feels out of place
- muscle spasms

HIPS, LEGS

- pain in buttocks
- pain down legs
- knee pain
- leg cramps
- numbness

DO YOU HAVE:

- high blood pressure
- low blood pressure
- irregular heart beat
- stroke
- diabetes
- menstrual cramps
- constipation
- diarrhea
- cancer
- rheumatism
- arthritis
- nervousness
- fatigue
- stress
- depression

LIST ANY COMPLAINTS YOUR SPOUSE HAS OR HAS HAD: _____

LIST ANY COMPLAINTS YOUR CHILDREN HAVE OR HAVE HAD: _____

LIST ANY MEDICATIONS THAT YOU ARE NOW TAKING: _____

PLEASE NOTE ANY OTHER PROBLEMS YOU HAVE THAT ARE NOT LISTED ABOVE: _____

ARE YOU PREGNANT: YES _____ NO _____

WHO MAY WE THANK FOR REFERRING YOU? _____

AUTHORIZATION AND ASSIGNMENT

AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

SIGNATURE

WITNESS

DATE

NOTICE OF ASSIGNMENT

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

SIGNATURE

WITNESS

DATE

ASSIGNMENT AND/OR RELEASE AUTHORIZATION IS GRANTED TO:

**DR. JOHN I. KELLY
5461 BELLS FERRY ROAD
ACWORTH, GEORGIA 30102
770-928-8800**

TERM OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for care, it is essential for both to be working towards the same objective.

Chiropractic had only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature

Date

Consent to evaluate and adjust a minor child

I _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that, x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

Signature

Date

CHIROPRACTIC HEALTH CENTER

John I. Kelly, D.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual Refused to Sign

_____ Communication Barriers Prohibited Obtaining the Acknowledgment

_____ An Emergency Situation Prevented Us from Obtaining Acknowledgement

_____ Other (Please Specify)
