PERRY CHIROPRACTIC HEALTH CENTER

1207 C Main Street
Perry, GA 31069
Ph: 478-987-9666
Fx: 478-988-8091

Patient Name: _____
Date Of Birth: _____
Date Of Exam: _____

PATIENT INFORMATION

First Name: _____ Nick Name: _____

Last Name: _____ Middle Name: _____ Suffix: _____

Address 1: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Mobile Phone: _____

Primary E-mail: _____

By providing my e-mail address, I authorize my doctor to contact me via the email address(es) provided.

Preferred Contact Method: (check one) ☐ Primary Phone ☐ Mobile Phone

Birthday: ____/____/____ **Age:** _____ **SSN:** _____

Gender: (check one) ☐ Male ☐ Female ☐ Unspecified

Race: (check one)

☐ White	☐ Black/African American	☐ Hispanic	☐ American Indian/Alaskan	☐ Korean
☐ Asian	☐ Native Hawaiian or Pacific Islander	☐ Japanese	☐ Guamanian or Chamorro	☐ Samoan
☐ Chinese	☐ Other_____	☐ Vietnamese	☐ I chose not to specify	☐ Multi-Racial

Preferred Language: _____

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I chose not to specify

Insurance Company: _____

Address: _____ **Policy Number:** _____

In case of emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

I AUTHORIZE A PAYMENT OF MEDICAL BENEFITS TO: PERRY CHIROPRACTIC HEALTH CENTER, OR DR. BRIAN GILLIS, D.C. FOR SERVICES RENDERED

SIGNATURE _____ **DATE** _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS

SIGNATURE _____ **DATE** _____

PERSONAL AUTHORIZING CARE/RESPONSIBILITY:

SIGNATURE _____ **DATE** _____

SECURITY QUESTION: (pick one)

☐ In what city were you born? ☐ What is your favorite movie? ☐ What's your mother's maiden name?

☐ On what street did you grow up? ☐ When is your anniversary? **Answer to security question:** _____

Personal ID #: _____

Must be at least a 6 digit #, ie: Date of birth or phone #. This is how you will now sign-in so you must remember it!

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PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

_____

Please list any surgeries you have had over the course of your life: _____

_____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? ☐Yes ☐No **If yes, please list:** _____

List any medications you are taking: _____

_____

FAMILY HISTORY

Mother: ☐Living ☐Deceased List any medical problems: _____

Father: ☐Living ☐Deceased List any medical problems: _____

List any problems common in your family: ☐Cancer ☐Diabetes ☐Heart disease ☐High blood pressure ☐Stroke ☐Arthritis ☐Scoliosis ☐Thyroid disease ☐Osteoporosis _____

SOCIAL HISTORY

Marital status: ☐Married ☐Single ☐Divorced ☐Common Law ☐Engaged ☐Widowed

Do you have any children? ☐Yes ☐No If yes, how many? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much & how often? _____

Do you smoke? ☐ Yes ☐ No ☐ Former If yes, how much, how often, & how long? _____
If yes, what is your interest in quitting smoking? (Not Interested) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (Very Interested)

Has any doctor diagnosed you with Hypertension or Diabetes? ☐ No ☐Hypertension ☐ Type I Diabetes ☐ Type II Diabetes
If yes to Diabetes, was your blood lab-work test for **hemoglobin a1c> 9.0%?** ☐ Yes ☐ No ☐Not Sure
Do you use any illegal drugs? ☐Yes ☐No If yes, what drugs, how often & how long? _____

Are you currently employed? ☐Yes ☐No If yes, what is your occupation? _____

Who is your current employer? _____ **How long have you been at this job?** _____

PERSONAL HEALTH GOALS

☐Improve Nutrition/Eating Habits	☐Lower Cholesterol	☐Get off Medications	☐Feel Better
☐Weight Loss/Fat Loss	☐Lower Blood Pressure	☐Improved Sleep	☐Look Better
☐Increase Lean Muscle Mass	☐Start Exercising	☐Improved Energy	☐Reduce Stress
☐Increase Bone Density	☐Improved Posture	☐Improved Outlook/Happiness	

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:

Exercise_____ **Sleep** _____ **Diet** _____ **Stress Level** _____ **Water Intake** _____ **Energy Level**_____
Do you take: Omega 3 (Fish Oil)? ☐ Yes ☐ No **Vitamin D3?** ☐ Yes ☐No **Probiotics?** ☐ Yes ☐ No

Who is your Family Physician or Primary Doctor that monitors you? _____

When was the last time you had blood work done? _____

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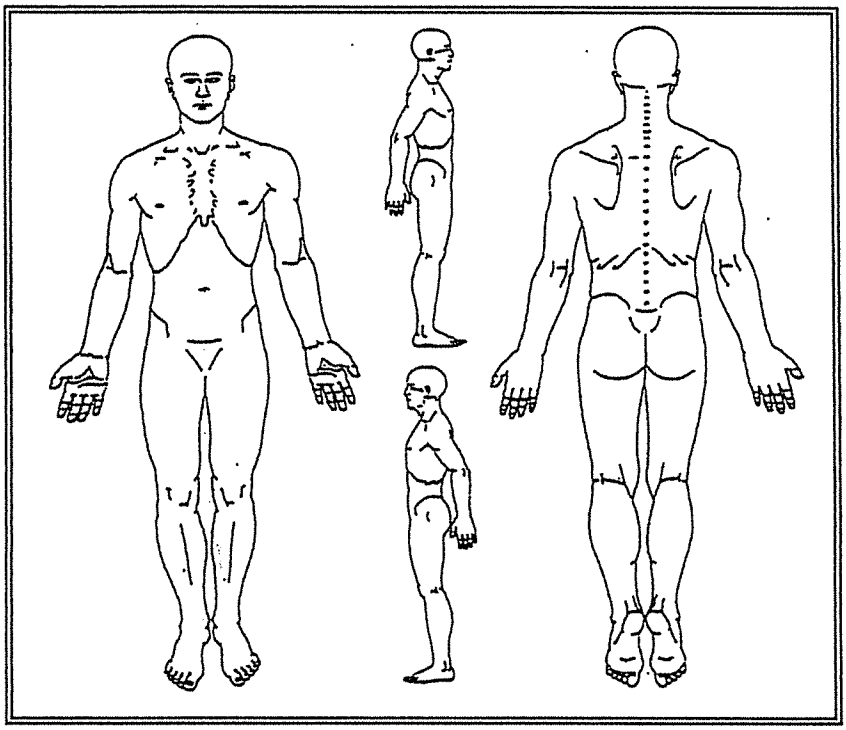
Please indicate the main reason you are seeing us today: _____

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Do you have any other health conditions, regardless of whether you think it's related to your spine:

_____

_____

Is there any radiating pain into the arms or legs? _____ **Is there any numbness or tingling?** _____

INFORMED CONSENT

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropratic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS & DIAGNOSIS

A doctor of chiropractic conducts a clinical analysis to determine if you are a chiropractic canidates. If it is determined you are a chiropractic canidate, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not be giving a chiropractic adjusment, or health care, if he/she is aware that such care may be contraindicated. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is availble to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many vaiables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing.

_____

Date Signature

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **PERRY CHIROPRACTIC HEALTH CENTER** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ☐ I give permission to **PCHC** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, thank you cards, testimonials, marketing materials, information about treatment alternatives or other health related information.
- ☐ If **PCHC** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- ☐ I give **PCHC** permission to treat me in an open therapy room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- ☐ By signing this form you are giving **PCHC** permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of PCHC. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **PCHC** for its own use/disclosure of PHI.
(Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **PCHC** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU * *

_____
Print Name of Patient

_____
Signature of Patient

_____
Date

_____
Signature of Personal Representative

_____
Description of Representative's Authority To Act for Patient:

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REVIEW OF SYMPTOMS

Please use the 0 to 4 guide below to rate each of the symptoms on this page according to your health status over the past 30 days.

0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia
Total_____

EYES
_____Watery or Itchy Eyes
_____Swollen, Reddened or Sticky Eyelids
_____Bags or Dark Circles Under Eyes
_____Blurred or Tunnel Vision
(does not include near or far-sighted)
Total_____

EARS
_____Itchy Ears
_____Earaches, Ear Infections
_____Drainage from Ear
_____Ringing in Ears, Hearing Loss
Total_____

NOSE
_____Stuffy Nose
_____Sinus Problems
_____Hay Fever
_____Sneezing Attacks
_____Excessive Mucus Formation
Total_____

MOUTH/THROAT
_____Chronic Coughing
_____Gagging, Frequent Need to Clear Throat
_____Sore Throat, Hoarseness, Loss of Voice
_____Swollen or Discolored Tongue, Gums/Lips
_____Canker Sores
Total_____

SKIN
_____Acne
_____Hives, Rashes, Dry Skin
_____Hair Loss
_____Flushing, Hot Flashes
_____Excessive Sweating
Total_____

ENERGY/ACTIVITY
_____Fatigue, Sluggishness
_____Apathy, Lethargy
_____Hyperactivity
_____Restlessness
Total_____

WEIGHT
_____Binge Eating/Drinking
_____Craving Certain Foods
_____Excessive Weight
_____Compulsive Eating
_____Water Retention
_____Underweight
Total_____

EMOTIONS
_____Mood Swings
_____Anxiety, Fear, Nervousness
_____Anger, Irritability, Aggressiveness
_____Depression
Total_____

MIND
_____Poor Memory
_____Confusion, Poor Comprehension
_____Poor Concentration
_____Poor Physical Condition
_____Difficulty in Making Decisions
_____Stuttering or Stammering
_____Slurred Speech
_____Learning Disabilities
Total_____

JOINTS/MUSCLE
_____Pain or Aches in Joints
_____Arthritis
_____Stiffness or Limited Movement
_____Pain or Aches in Muscles
_____Feeling of Weakness or Tiredness
Total_____

LUNGS
_____Chest Congestion
_____Asthma, Bronchitis
_____Shortness of Breath
_____Difficulty Breathing
Total_____

HEART
_____Irregular or Skipped Heartbeat
_____Rapid or Pounding Heartbeat
_____Chest Pain
Total_____

DIGESTIVE TRACT
_____Nausea, Vomiting
_____Diarrhea
_____Constipation
_____Bloated Feeling
_____Belching, Passing Gas
_____Heartburn
_____Intestinal/Stomach Pain
Total_____

OTHER
_____Frequent Illness
_____Frequent or Urgent Urination
_____Genital Itch or Discharge
Total_____

GRAND TOTAL _____

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Please answer the questions on a scale of 1 to 10 , 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement... ***BE HONEST WITH YOURSELF.***

Physical Stress

1. I am a physically fit person and formally exercise on a regular basis.
   a. 1 2 3 4 5 6 7 8 9 10
2. I have a physically attractive body that I am proud to look at in the mirror.
   a. 1 2 3 4 5 6 7 8 9 10
3. I have not had many traumas in my life (auto accident, broken bones, bad falls).
   a. 1 2 3 4 5 6 7 8 9 10
4. I get at least 7 hours of sleep, 7 days a week
   a. 1 2 3 4 5 6 7 8 9 10
5. I have gotten regular Chiropractic care within the past 5 years.
   a. 1 2 3 4 5 6 7 8 9 10

Total _____

Emotional/Mental Stress

6. I am a calm, peaceful person. I can shut my mind off and focus my mind at will.
   1 2 3 4 5 6 7 8 9 10
7. I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis.
   1 2 3 4 5 6 7 8 9 10
8. Most of the time, I am truly happy and feel a sense of purpose in my life.
   1 2 3 4 5 6 7 8 9 10
9. I have healthy relationships and a rich social network of friends and activities.
   1 2 3 4 5 6 7 8 9 10
10. I am organized, have time for myself, and can prioritize the important tasks in my life.
    1 2 3 4 5 6 7 8 9 10

Total _____

Chemical/Nutritional Stress

11. I eat 4-6 small meals daily and properly combine my protein, carbs. and fats.
    1 2 3 4 5 6 7 8 9 10
12. I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).
    1 2 3 4 5 6 7 8 9 10
13. I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.
    1 2 3 4 5 6 7 8 9 10
14. I do not smoke cigarettes.
    1 2 3 4 5 6 7 8 9 10
15. I drink water as my primary beverage and consume at least 30 ounces per day.
    1 2 3 4 5 6 7 8 9 10

Total_____ **Total of all 3 (physical, emotional, chemical) sections**_____