



New Patient Paperwork

Welcome to our clinic. This information is needed so we can better serve you. Please fill in **ALL** portions of the form. If you need help, please don't hesitate to ask!

Name: _____
Last First MI

Date of Birth: ____/____/____ Sex: Male Female SS#: _____

Mailing Address: _____

Email: _____ Phone: _____

Please check your contact preference: Call Text Email

Marital Status: Single Married Divorced Widowed Separated Minor

Race: Caucasian African American Asian Native American Latin American Other _____

Ethnicity: Hispanic Latino Non-Hispanic/Non-Latino Decline to Answer

Occupation: _____ Employer: _____

Spouse Occupation: _____ Spouse Employer: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Names of children/ages: _____

Financial Information:

Do you have health insurance? Yes No Name of Carrier: _____

Are you the policy holder? Yes No If no, who is the policy holder: Spouse Parent Employer Other

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's SS#: _____ Policy Holder's Employer: _____

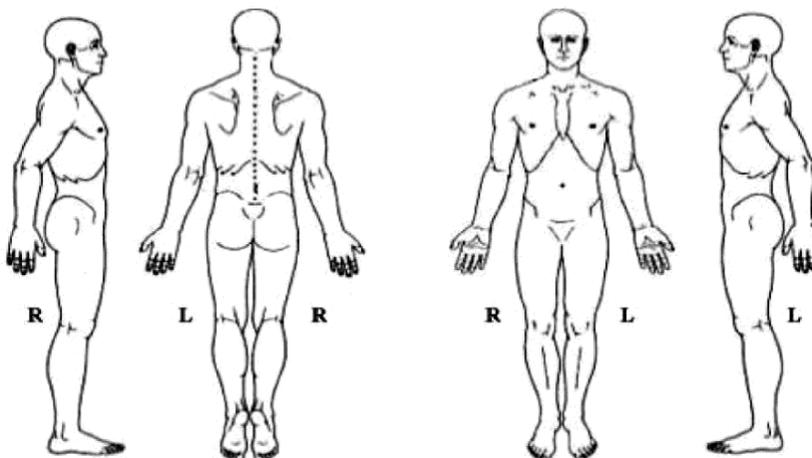
Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE OUR OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) AND IDENTIFICATION

Our Philosophy:

You deserve to be healthy, and our goal is for you to feel better than you have in years! When you were born, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, life is stressful. Emotional and physical stress, accidents, and other challenges can seriously impact your health. Today we will find out what is causing your health problems and determine a care plan that restores your health, so you can live the quality of life you deserve.

Please mark the area of your pain or symptoms in the image below.



What is your **main** health concern/reason for your visit today?

Briefly describe any other complaints:

How long have you had the **main** health concern/problem? ____ Days ____ Weeks ____ Months ____ Years

Under what circumstances did the pain begin?

- Accident at work Accident at home At work but not incident Pain just began, no reason
 Following illness Following surgery Motor Vehicle Accident Repetitive stress / overuse
 Following exercise/sports Other _____

Where is the problem located? Head Neck Shoulder Elbow Wrist/Hand Upper Back Middle Back
 Lower Back Hip Knee Foot/Ankle Other: _____

How would you describe your pain? Aching Stabbing Shooting Numb Throbbing Sharp Burning

Your **AVERAGE** pain score is: (circle one)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
None mild moderate severe very severe WORST

When your pain is at its **WORST** your pain score is: (circle one)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
None mild moderate severe very severe WORST

What percent of the day are you in pain?

- Occasionally (1 - 25%)
- Periodically (26 - 50%)
- Frequently (51 - 75%)
- Constantly (76 - 100%)

Which of the following make your pain better? (Check all that apply) Relaxation Stretching Sitting

- Standing Walking Lying down Medication Ice Heat Nothing makes it feel better
- Other: _____

Which of the following make your pain worse? (Check all that apply) Work Computer/Desk Exercise/Sports

- Lifting Lying Down Sitting Standing Sit to Stand Twisting Bending Walking
- Stairs Other: _____

Does this pain radiate/travel anywhere? Yes No If yes, where? _____

Have you seen any other Doctors for this condition? Yes No

If yes, what treatment was rendered? _____

Have you ever been to the Chiropractor before? Yes No

If yes: When? For how long?

In the past 12 months, have you had an X-ray, MRI, or CT ?

Type of Imaging: _____ Date of Exam: _____

Facility Performed: _____ Phone: _____

List all surgical history:

Who is your Primary Care Physician? _____

Medications/Supplements you are currently taking (Include over the counter, herbal, and natural remedies):

Please list any general or medication **allergies** and your reaction to them:

Allergy	Reaction

Other Present Medical Signs or Symptoms

<p><u>Constitutional Symptoms</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Chills/Fever <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Poor sleep/ insomnia <input type="checkbox"/> Night sweats <input type="checkbox"/> Recent weight loss <input type="checkbox"/> Recent weight gain	<p><u>Genitourinary</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Frequency <input type="checkbox"/> Incontinence <input type="checkbox"/> Urgency	<p><u>Neurological</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Paralysis/Paresis <input type="checkbox"/> Disorientation <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Unbalanced/Unsteady	<p><u>Gastrointestinal</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Hepatitis
<p><u>Eyes, Ears, Nose and Throat</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Double/Blurred Vision <input type="checkbox"/> Earache R or L <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Difficulty swallowing	<p><u>Musculoskeletal</u></p> <input type="checkbox"/> No symptoms	<p><u>Psychiatric</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Anxiety <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Stressed <input type="checkbox"/> Mood Swings <input type="checkbox"/> Change in behavior	<p><u>Respiratory</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Trouble Breathing <input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Pain with exertion
<p><u>Cardiovascular</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Chest Discomfort <input type="checkbox"/> Chest Pain <input type="checkbox"/> Fainting <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Leg Cramps at Rest <input type="checkbox"/> Leg Cramps on Exertion <input type="checkbox"/> Leg Swelling	<p>• Neck:</p> <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Tenderness	<p><u>Endocrine</u></p> <input type="checkbox"/> No symptoms <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Hormonal Imbalance	<p><u>Please list any other signs or symptoms you are having that are not listed:</u></p> <hr/> <hr/> <hr/>
	<p>• Back:</p> <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Tenderness		
	<p>• Joints: (circle) hips, knees, feet, shoulder, elbow, hands</p> <input type="checkbox"/> Aching <input type="checkbox"/> Arthritis <input type="checkbox"/> Limited joint movement <input type="checkbox"/> Redness <input type="checkbox"/> Morning Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Tenderness		
	<p>• Muscles</p> <input type="checkbox"/> Aches <input type="checkbox"/> Weakness		

Past Medical History

<p><u>Neurological:</u></p> <input type="checkbox"/> Migraines / Headaches <input type="checkbox"/> Stroke / TIA <input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Concussion <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Multiple Sclerosis	<p><u>Endocrine:</u></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Diabetic Neuropathy <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid Disease (Grave's Disease) <input type="checkbox"/> Hypothyroid Disease (Hashimoto's Disease)	<p><u>Cardiovascular:</u></p> <input type="checkbox"/> High Blood Pressure/HTN <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Deep Vein Thrombosis <input type="checkbox"/> Blood clots <input type="checkbox"/> Pacemaker	<p><u>Rheumatology:</u></p> <input type="checkbox"/> Osteoarthritis: Location: _____ <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Osteoporosis / Osteopenia <input type="checkbox"/> Gout <input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Lupus <input type="checkbox"/> Other: _____
<p><u>Musculoskeletal:</u></p> <input type="checkbox"/> Shoulder injury <input type="checkbox"/> Elbow injury <input type="checkbox"/> Wrist/hand injury <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Hip injury <input type="checkbox"/> Knee injury <input type="checkbox"/> Foot/ankle injury <input type="checkbox"/> Joint Replacements	<p><u>Urinary & Reproductive:</u></p> <input type="checkbox"/> Incontinence <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> STD's: _____ <input type="checkbox"/> Endometriosis <input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> PCOS <input type="checkbox"/> Other: _____	<p><u>Respiratory:</u></p> <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Covid-19	<p><u>Please list any other signs or symptoms you are having that are not listed:</u></p> <hr/> <hr/> <hr/>
<p><u>Renal:</u></p> <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Dialysis <input type="checkbox"/> Nephritis	<p><u>Oncology:</u></p> <input type="checkbox"/> Cancer: _____	<p><u>Gastrointestinal:</u></p> <input type="checkbox"/> GERD <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Gallbladder / Gallstones <input type="checkbox"/> Gluten Intolerance (Celiac Disease) <input type="checkbox"/> Pancreatitis	

DIRECTIONS TO ATLANTA SPINE AND WELLNESS

******PLEASE NOTE THAT GPS DEVICES RECOGNIZE 5070 PEACHTREE BLVD AS THE PARKVIEW ON PEACHTREE COMPLEX. WE ARE LOCATED INSIDE THE COMPLEX, AMONG OTHER OFFICES, IN SUITE E-170. OUR NEAREST NEIGHBOR IS WINDSOR PARKVIEW LEASING OFFICE. PARKING IS AVAILABLE, FOR FREE, IN THE STRUCTURE OR SURROUNDING LOTS******

Traveling on I-285E:

Traveling eastbound, use the right lane to take exit 30 to Chamblee-Dunwoody Rd. Travel 2 miles south, turn right onto Peachtree Blvd. Travel 0.5 miles southwest and turn right onto Clairmont Rd. Drive over small bridge into Parkview complex. Suite E-170 located just beyond Windsor Leasing office on your right facing interior of complex. Enter at sign for Atlanta Spine and Wellness.

Traveling on I-285W:

Traveling westbound, take exit 31A for GA-141 SOUTH Peachtree Ind Blvd toward Chamblee. Continue on Peachtree Blvd for 2 miles then turn right on Clairmont Rd. into Parkview complex. Drive over small bridge into Parkview complex. Suite E-170 located just beyond Windsor Leasing office on your right facing interior of complex. Enter at sign for Atlanta Spine and Wellness.

From Downtown (I75/85N):

Merge onto I85N. Take exit 91 towards US-23/GA-155/Clairmont Rd/Decatur. Use the left 2 lanes to turn left onto US-23 N/Clairmont Rd, continue straight for 2.2 miles onto Clairmont Rd. Travel straight across Peachtree Blvd, over small bridge, into Parkview Complex. Suite E-170 located just beyond Windsor Leasing office on your right facing interior of complex. Enter at sign for Atlanta Spine and Wellness.

From I85S:

Traveling southbound, cross over I-285 so you are inside the perimeter. Use the right 2 lanes to take Exit 94 for Chamblee-Tucker Rd toward Mercer Univ. Keep right at the fork and merge onto Chamblee Tucker Rd. Continue for 2 miles and merge onto Chamblee Tucker Rd. Continue for 0.2 mile and turn slightly left onto New Peachtree Rd. Continue for 0.3 mile and turn right onto Clairmont Rd. Continue north, cross over Peachtree Blvd. Drive to the left over small bridge into Parkview complex. Suite E-170 located just beyond Windsor Leasing office on your right facing interior of complex. Enter at sign for Atlanta Spine and Wellness.

From Chamblee Marta via Chamblee Rail Trail:

Exit Chamblee Marta station onto Chamblee Tucker Rd. Walk north on Chamblee Tucker Rd. 0.3 mile until you reach Chamblee Rail Trail entrance on your left. Enter rail trail, heading west, Wal Mart will be on your right if you're on trail Cross under Clairmont Rd bridge above you. Stay on trail north. Take tunnel under Peachtree Blvd. Take staircase up to Parkview Complex. Suite E-170 located just beyond Windsor Leasing office on your right facing interior of complex. Enter at sign for Atlanta Spine and Wellness.