ATLANTA SPINE & WELLNESS ROSWELL

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: _____

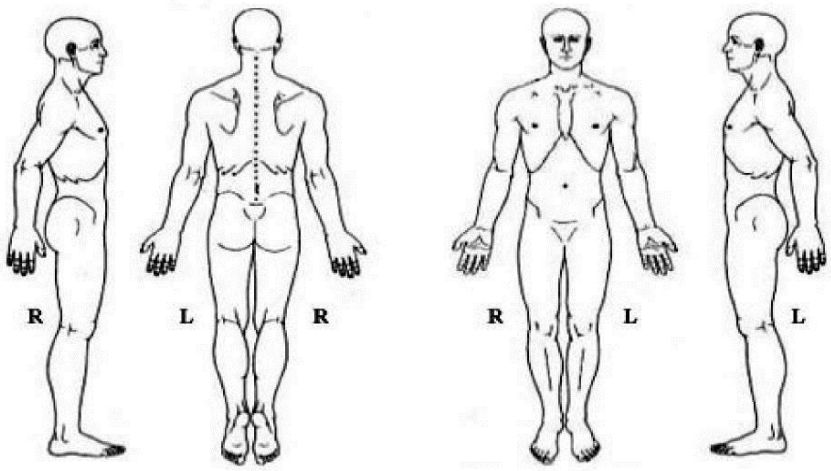
Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

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

Constitutional Symptoms
- ☐ No symptoms
- ☐ Chills/Fever
- ☐ Loss of appetite
- ☐ Poor sleep/ insomnia
- ☐ Night sweats
- ☐ Recent weight loss
- ☐ Recent weight gain

Eyes, Ears, Nose and Throat
- ☐ No symptoms
- ☐ Double/Blurred Vision
- ☐ Earache R or L
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ Nasal Congestion
- ☐ Sinus Trouble
- ☐ Difficulty swallowing

Cardiovascular
- ☐ No symptoms
- ☐ Chest Discomfort
- ☐ Chest Pain
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Leg Cramps at Rest
- ☐ Leg Cramps on Exertion
- ☐ Leg Swelling

Genitourinary
- ☐ No symptoms
- ☐ Frequency
- ☐ Incontinence
- ☐ Urgency

Musculoskeletal
- ☐ No symptoms
- • Neck:
  - ☐ Pain
  - ☐ Stiffness
  - ☐ Tenderness
- • Back:
  - ☐ Pain
  - ☐ Stiffness
  - ☐ Tenderness
- • Joints: (circle) hips, knees, feet, shoulder, elbow, hands
  - ☐ Aching
  - ☐ Arthritis
  - ☐ Limited joint movement
  - ☐ Redness
  - ☐ Morning Stiffness
  - ☐ Swelling
  - ☐ Tenderness
- • Muscles
  - ☐ Aches
  - ☐ Weakness

Neurological
- ☐ No symptoms
- ☐ Headaches/Migraines
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis/Paresis
- ☐ Disorientation
- ☐ Vertigo/Dizziness
- ☐ Unbalanced/Unsteady

Psychiatric
- ☐ No symptoms
- ☐ Anxiety
- ☐ Nervousness
- ☐ Depression
- ☐ Stressed
- ☐ Mood Swings
- ☐ Change in behavior

Endocrine
- ☐ No symptoms
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Sweating
- ☐ Hot Flashes
- ☐ Excessive thirst
- ☐ Hormonal Imbalance

Gastrointestinal
- ☐ No symptoms
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Hepatitis

Respiratory
- ☐ No symptoms
- ☐ Trouble Breathing
- ☐ Asthma
- ☐ Cough
- ☐ Pain with exertion

Please list any other signs or symptoms you are having that are not listed:

_____

_____

_____

Past Medical History

Neurological:
- ☐ Migraines / Headaches
- ☐ Stroke / TIA
- ☐ Peripheral Neuropathy
- ☐ Concussion
- ☐ Spinal Cord Injury
- ☐ Multiple Sclerosis

Musculoskeletal:
- ☐ Shoulder injury
- ☐ Elbow injury
- ☐ Wrist/hand injury
- ☐ Carpal Tunnel
- ☐ Hip injury
- ☐ Knee injury
- ☐ Foot/ankle injury
- ☐ Joint Replacements

Renal:
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Dialysis
- ☐ Nephritis

Endocrine:
- ☐ Diabetes
- ☐ Diabetic Neuropathy
- ☐ Hypoglycemia
- ☐ Hyperthyroid Disease (Grave's Disease)
- ☐ Hypothyroid Disease (Hashimoto's Disease)

Urinary & Reproductive:
- ☐ Incontinence
- ☐ Enlarged Prostate
- ☐ STD's: _____
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ PCOS
- ☐ Other: _____

Oncology:
- ☐ Cancer: _____

Cardiovascular:
- ☐ High Blood Pressure/HTN
- ☐ Vascular Disease
- ☐ Deep Vein Thrombosis
- ☐ Blood clots
- ☐ Pacemaker

Respiratory:
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Pulmonary Hypertension
- ☐ Tuberculosis
- ☐ Covid-19

Gastrointestinal:
- ☐ GERD
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Gallbladder / Gallstones
- ☐ Gluten Intolerance (Celiac Disease)
- ☐ Pancreatitis

Rheumatology:
- ☐ Osteoarthritis: Location: _____
- ☐ Rheumatoid Arthritis
- ☐ Psoriatic Arthritis
- ☐ Osteoporosis / Osteopenia
- ☐ Gout
- ☐ Ankylosing spondylitis
- ☐ Lupus
- ☐ Other: _____

Please list any other signs or symptoms you are having that are not listed:

_____

_____

_____

Family & Social History

Is there a family history of?	Disc Disease	Heart Disease	Arthritis	Cancer	Diabetes
Father's Family	❑	❑	❑	❑	❑
Mother's Family	❑	❑	❑	❑	❑

Females only: Are you pregnant, planning a pregnancy or currently breastfeeding? ❑ Yes ❑ No

Tell us about your home environment? ❑ Live Alone ❑ With Spouse ❑ With Children ❑ With Relatives ❑ With Friends/Roommates ❑ Assisted Living Home ❑ Caretaker

Do you exercise? ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Describe your sleep habits per night: ❑ Constant ❑ Interrupted ❑ 8+ Hours ❑ 6-7 Hours ❑ 5 or less

Do your work activities mostly involve? ❑ Sitting ❑ Standing ❑ Computers ❑ Sit to Stand Desk ❑ Light Labor ❑ Heavy Labor

Have you ever smoked? ❑ No ❑ Yes ❑ Cigar ❑ Pipe ❑ Cigarettes If yes, _____/day _____ # of years

Do you drink caffeinated beverages? ❑ Coffee ❑ Teas ❑ Sodas ❑ Energy Drinks regularly? _____/day

Do you use recreational drugs? ❑ No ❑ Yes If yes, what type? _____

Health Goals

On your second visit we will review the results of your evaluation and discuss a treatment plan that meets your goals and helps you to be as healthy as possible.

As a result of my treatment in this office, I would like to... (please check all that apply)

❑ Feel better quickly ❑ Have a healthier body by keeping my nervous system healthy
❑ Live a healthier lifestyle ❑ Live a more active lifestyle ❑Have a healthier spine

What other health goals do you have? _____

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT:

I certify that the above information is true and correct to the best of my knowledge. I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. When and if any charges that may be incurred for services are not paid in full by me or provided insurance, I agree to pay any and all collection and/or attorney fees with the original balance due. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

PATIENT SIGNATURE _____ **DATE** _____

DIRECTIONS TO ATLANTA SPINE AND WELLNESS ROSWELL

Traveling from 400 N:
Take Exit 7B – Holcomb Bridge Rd
Head west on Holcomb Bridge Rd for 5 miles and the business complex will be on your left. You will need to do a U-turn at the next break in the median. Turn right into the complex and Atlanta Spine and Wellness Roswell is the first office on the right. Suite 450.

Traveling from 400 S:
Take Exit 7 – Holcomb Bridge Rd
Turn right to head west on Holcomb Bridge Rd for 5 miles and the business complex will be on your left. You will need to do a U-turn at the next break in the median. Turn right into the complex and Atlanta Spine and Wellness Roswell is the first office on the right. Suite 450.

Traveling towards 400:
If you are traveling east on Woodstock Rd/Hwy 92 towards 400, turn right into the complex and Atlanta Spine and Wellness Roswell is the first office on the right. Suite 450.