ACTIVE CARE ATLANTA
CHIROPRACTIC
JOINT & SOFT TISSUE

ACTIVE CARE ATLANTA
6290 Abbotts Bridge Rd, Suite 204
Johns Creek, GA 30097
T: 770.559.4236 F: 770.559.4795
www.ActiveCareAtlanta.com

Welcome to Active Care Atlanta

Name _____ Birth Date _____ Age _____ ☐ Male ☐ Female

Cell # _____ Home # _____ Work # _____

Address _____ City, State & Zip _____

Email _____

Occupation _____ Employer _____

Social Security # _____-_____-_____ Marital Status ☐ Single ☐ Married ☐ Divorce ☐ Other

Emergency Contact _____ Relation _____ Phone # _____

How did you hear about us? ☐ Friend/Family _____ ☐ Online ☐ Insurance Website

☐ Attorney _____ ☐ Event _____ ☐ Sign

☐ Physician's Referral _____ ☐ Other _____

1. Reason for today's visit _____

2. What's your current pain level now? No pain 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst

3. Indicate the area(s) showing the type of discomfort you have using the provided markings.

Aching ○

Dull Pain ////

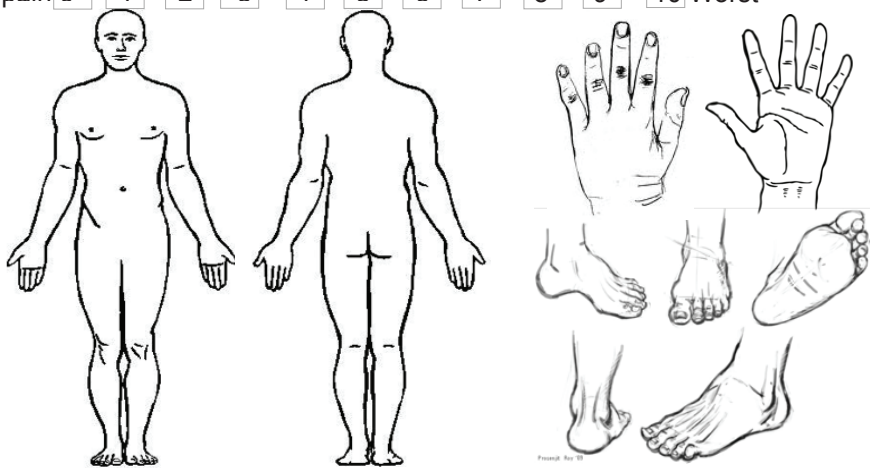
Stabbing ✕

Tingling ✶

Numbness ◇

Pins & Needles △

Burning ☐



4. Is this visit related to an auto accident or work related injury? ☐ No ☐ Yes *Incident Date* _____

5. How long have you had the symptom? _____ 6. If you've had the issue before, *When* _____

7. What caused the symptom/injury to occur? _____ ☐ Don't know

8. What makes it ***better***? _____

9. What makes it ***worse***? _____

10. List any other doctors and type of treatment received for above conditions _____

_____ *When* _____

11. Have you had Xray, MRI, CT, etc. for the condition? *When & Where* _____

12. List all medications you are currently taking (OTC, Prescriptions, Vitamins, Herbs...) _____

_____

13. Have you had previous chiropractic care? ☐ More than 30 times ☐ 10 to 30 times ☐ Less than 10 times ☐ Never

14. Can you perform daily home activities? ☐ All ☐ Some ☐ None

15. Rate your stress level over the last 30 days? Low 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 High

16. ***FEMALE ONLY*** » Is there any chance that you are pregnant? ☐ No ☐ Yes / Maybe

Review of Systems: Do you have any of the following? (Check all that apply)

ENDOCRINE			SKIN CONDITIONS			HEMATOLOGIC			CARDIOVASCULAR		
☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current
Thyroid			Rash or Itching			Hepatitis			Poor Circulation		
Diabetes			Change in skin color			Blood Clots			High Blood Pressure		
Hair Loss			Lumps / Masses			Cancer			High Cholesterol		
Menopause			Varicose Veins			Easily Bruising			Heart Disease		
Appetite Change						Bleeding			Heart Attack		
CONSTITUTIONAL			**NEUROLOGIC**			**GASTROINTESTINAL**			Aortic Aneurism		
☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current	Pace Maker		
Weight Loss/Gain			Stroke			Gall Bladder			Jaw Pain		
Low Energy			Seizures			Bowel Problems			Irregular Heartbeat		
Chills/Fever			Head Injury			Diarrhea			Swelling of Legs		
Night Sweats			Brain Aneurysm			Constipation			Chest Pain		
PSYCHIATRIC			Pinched Nerves			Liver Problems			**EYES**		
☐ None of below	past	current	Parkinson's			Ulcers			☐ None of below	past	current
Depression/Anxiety			Carpal Tunnel			Nausea/Vomiting			Glaucoma		
Stress			Vertigo			Bloody Stool			Double Vision		
Memory Loss									Blurred Vision		
MUSCULOSKELETAL			**EAR/NOSE/THROAT**			**GENITOURINARY**			**RESPIRATORY**		
☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current
Gout			Difficulty Swallowing			Kidney Disease			Asthma		
Arthritis			Dizziness			Kidney Stones			Tuberculosis		
Muscle Weakness			Hearing Loss			Frequent Urination			Short of Breath		
Osteoporosis			Nosebleeds			Burning Urination			Pneumonia		
Broken Bones			Bleeding Gums			Blood in Urine			Frequent Cough		
Joint Replacement											

Please list other conditions not listed above _____

1. List all surgeries you have had in the past _____
2. Have you had a car accident before ☐ Never ☐ Yes *When* _____
3. Family History: Tell us about any conditions your immediate family members are being treated for

_____

Social History

4. Do you consume alcohol? ☐ No *if yes,* ☐ Beer ☐ Liquor ☐ Wine How much & often? _____
5. Do you consume caffeine? ☐ No *if yes,* ☐ Coffee ☐ Soda ☐ Tea How much & often? _____
6. How's your diet? ☐ Healthy/Controlled ☐ Gluten Free/Paleo ☐ Vegetarian
   ☐ High Fat ☐ High Protein ☐ High Carbohydrate ☐ High Fiber ☐ High Sugar ☐ High Salt
   ☐ Low Fat ☐ Low Protein ☐ Low Carbohydrate ☐ Low Fiber ☐ Low Sugar ☐ Low Salt ☐ Other _____
7. Do you smoke? ☐ No *if yes,* How much, often & long have you been smoking? _____
8. Do you exercise? ☐ None ☐ _____ days /week ☐ Stopped recently What type _____
9. Does your condition limit your exercise level? ☐ A lot ☐ Some ☐ No

The above information is true and accurate to the best of my knowledge.

Patient / Guardian's Name _____ Signature _____ Date _____

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Payment Policies

(Please initial below)

_____ (initial) Our policy requires payment for all services at the time of visit. I understand that I am fully responsible for all charges.

_____ (initial) Our cancellation fee is $25.00 for a missed appointment without letting us know (via phone/voicemail/email) ***4 hrs before appointment time***. Appointment reminder service is complimentary but we urge you NOT to rely on it as technical issues can occur.

_____ (initial) I understand it is my responsibility to know what my plan covers. In the event that my insurance company does not cover/pay the service, I acknowledge that I am responsible to pay the service.

_____ (initial) Patient balances 90 days old will be forwarded to a collection agency and a 23% fee will be applied.

_____ (initial) If payment is mailed directly to me from an insurance company, I will bring in the check within 2 weeks of receipt.

_____ (initial) There will be a $25.00 service charge on all returned checks.

>>> *Guardian of under 18 yr*: I give permission for my child to be treated when I am not present. ☐ Yes ☐ No

Assignment of Benefit

---------- ***This section applies to patients wanting us to bill to insurance*** ----------

I direct and authorize **my insurance company to make payments *DIRECTLY* to ACTIVE CARE ATLANTA** for any and all benefits due as a result of my treatment.

I become fully financially responsible for any and all charges incurred in the course of my treatment, including services not covered or paid by my insurance.

I hereby authorize **ACTIVE CARE ATLANTA** to: **(1)** release any information necessary to my insurance carriers and attorney to secure payment of benefits; **(2)** process insurance claims generated in the course of treatment; **(3)** issue a complaint to my insurance carriers or the Insurance Commissioner on my behalf if necessary.

A photocopy of this assignment is to be considered as valid as an original.

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CONSENT TO TREATMENT

I give permission to all providers working for Active Care Atlanta to initiate care and provide treatment to me. This authorization does not expire and is effective as long as I am a patient.

Though rare, there are risks of complications associated with all health care procedures and treatments. These complications include but are not limited to: bruising, burns, muscle spasm, fractures, disc injuries and dislocations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Strokes have been the subject of tremendous disagreement. The occurrence of a stroke is exceedingly rare and is estimated to occur approximately once per 1 million to 5 million neck adjustments.

The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however it's your responsibility to inform the Doctor if you have a condition that would otherwise not come to the Doctor's attention.

By signing below, I've completely read the content above and I hereby give my consent to the treatment.

Patient / Guardian's Name _____ Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your **protected health information** (PHI). Our **Notice of Privacy Practices** details how we may use and disclose your PHI. You have the right to review our complete Notice which is located in the waiting room, front desk and our website.

By signing below you authorize our **use and disclosure of your PHI to third parties** for purposes related to treatment, payment, health care operations and those required by law. You also acknowledge that:

- **Active Care Atlanta** has a Notice of Privacy Practices you have had an opportunity to review.
- **Active Care Atlanta** may modify this Notice as needed at any time. If changes are made, they will be posted at our office.
- Certain situations may require the disclosure of patient PHI without patient authorization.
- Patient PHI may be used to contact patient as needed.
- Patient has the right to restrict the uses of his/her information.

The Patient may revoke this authorization at any time by submitting a written request to **Active Care Atlanta.** The request must include name, SS#, date of birth, address, a clear statement of intent to revoke this authorization and signature. This request is not effective until received and reviewed by **Active Care Atlanta**.

By signing below, I acknowledge Active Care Atlanta's Notice of Privacy Practices.

Patient / Guardian's Name _____ Signature _____ Date _____