CHIROPRACTIC WORKS
Family Health Center

1715 Howell Mill Road * Suite C-12 * Atlanta * Georgia * 30318 * (404)350-8000
www.AtlantaKidsChiro.com

Name:_____Date:_____

OUR MISSION STATEMENT

To be able to help as many people as we can, reach their potential, especially children

We are encouraging all our patients to help us in this most important and noble mission.

Patient Introduction

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. THANK YOU.

Personal History:

Your Name: _____ Age_____
First Middle Last

Childs's Name (if the patient):_____
First Middle Last

Address: _____
_____
_____

Last four of SS# _____

Cell#: _____ Bus#: _____ Cell Service Provider:_____

Email Address: _____

Birth Date: _____/_____/_____ Marital Status:_____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Ph/Cell# _____

Previous Chiropractor: _____

City: _____

Last visit to this Chiropractor: _____

Reason for leaving: _____
_____
_____

Present MD: _____ PH#:_____

City: _____

Referred to our Center by: _____

SIGNATURE: _____ DATE: _____

Our Fee Structure

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	$ 80.00
Radiology	$ 100.00
TOTAL	**$ 180.00**

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Our policy for **missed appointments** is simple. We recognize that things happen, please inform us of any possible absences prior to your scheduled time by calling the office. There is a service charge of $45 for missed appointments if you do not call, and let us know. Our missed appointment charges are donated to the International Chiropractic Pediatric Association in Pennsylvania for pediatric research.
(INITIAL)_____

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

SIGNATURE: _____DATE: _____
(Signature of Parent/Guardian required if patient under age 18)

Thank You!

Currently Pregnant? _____Y _____N – (if no skip to next page)

Due Date _____ I am in my _____ week of pregnancy

Pre-pregnancy weight _____ My Current Weight _____ Height _____

Childbirth preparation: Bradley _____ LaMaze _____ Other _____

Childbirth caregiver(s) Names: OB/GYN _____

Doula _____ Midwife _____

Supplements currently taking? _____Y _____N Medication currently taking? _____Y _____N Date of last visit to caregiver _____ Their name & phone # _____

I plan on giving birth at: Hospital _____ Home _____ Birth Center _____

Name of Hospital or Birth Center _____

Any traumas during this pregnancy? _____Y _____N If yes, please describe:

_____

_____

_____

Any hospitalizations during this pregnancy? _____Y _____N If yes, please describe:

_____

_____

Any medications during this pregnancy, including over the counter medication? _____Y _____N

Please describe _____

_____

Any fertility treatment? _____Y _____N If yes, please describe: _____

_____

_____

Any other information about your pregnancy? _____

Did you have chiropractic care during your previous pregnancies? _____Y _____N

<u>After 32nd Week of Pregnancy</u>

Position of baby: Head down _____Y _____N Posterior _____Y _____N

Breech or Mal-positioned _____ How was it confirmed? _____

Date confirmed: _____ Ultrasound by _____Y _____N Date: _____

How long do you believe baby has been in this position? _____

Adult Consultation History

What Are Your Main Complaint(s): _____

_____

How long have you suffered with this problem? _____
List all that you have tried to do to get rid of these problems that **DID NOT** work? _____
_____
_____

Have you become discouraged about handling this problem? YES _____ NO __
When your problem is at its worst, how does it make you feel? _____
_____

We want to help improve your quality of life. Tell us how the following areas of your life are affected?

WORK: _____
FAMILY: _____
HOBBIES: _____
LIFE: _____

Does handling this problem cause stress for you?_____
What do you do that makes this problem worse? _____
How much older does this issue make you feel? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us SOLVE this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem?

Constant ___, Intermittent ___, Occasional ___ Cyclic ___

What is the effect it has on your body functions? _____

How did it start? _____

SIGNATURE: _____ DATE: _____

Are you on any type of medication?_____, Please list all: _____
_____
_____

Could your problem have been caused by an injury at work?_____

If yes, please give us the details: _____
_____
_____

Have you been involved in any accident(s), falls or fights? YES _____ NO _____
Date of accident(s): _____

Any health issues left-over from these accidents? _____
_____
_____

Do you have any children? _____

Do they have any health problems that you are aware of? _____
_____

Is there any other information you would like us to know?_____
_____
_____
_____
_____

For Women Only

Date of your last menstrual period: _____

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Do they last more than 5 days? _____How long?_____

Do you suffer from PMS? _____

SIGNATURE: _____ DATE: _____

Special Summary Questions

List the 5 problems you want to get rid of, or your five goals that you would like to achieve.

1. _____
2. _____
3. _____
4. _____
5. _____

List everyone you have seen and what you have tried to do to get rid of these problems or reach these goals.

_____
_____
_____
_____
_____

Write down the things you are willing to do to get rid of your problem or reach your goals.

1. _____
2. _____
3. _____
4. _____
5. _____

Tell me what you would do that you haven't been able to do, after your problems are gone and you have reached your goals.

_____
_____
_____
_____

SIGNATURE: _____ DATE: _____

FAMILY HEALTH HISTORY

Patient Name: _____ **Date:** _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation **"C"** under his or her column. The designation "**P**" should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Press								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								

Additional Comments: _____

_____

_____

Thank you!