Confidential Health Information Questionnaire

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

Email address: Personal:_____ Work:_____

Mailing Address: _____

_____

Phone # (Home)_____ (Work)_____ (Cell) _____
Can we call you at work? ❑ Yes ❑ No Please check your contact preference: ❑ Home ❑ Work ❑ Cell

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

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
Language: ❑English ❑Spanish ❑Indian ❑Japanese ❑Chinese ❑Korean ❑French ❑German ❑Russian

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: _____

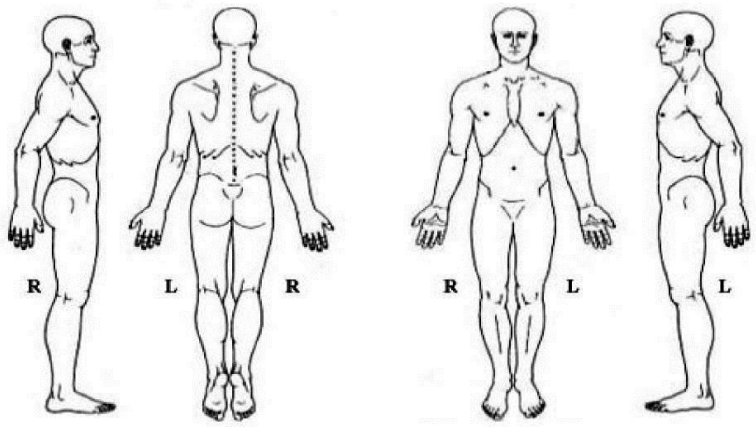
PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) AND IDENTIFICATION

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.

Current Health Condition:

Please shade/draw in the area of your pain or symptoms in the image below.



What is your chief complaint / main health concerns for your visit today?

_____

Please briefly describe any other complaints you would like for us to also address:

_____

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

When do your symptoms occur? ❑Constantly ❑ At Rest ❑With activity ❑ Other_____

Which statement best describes your pain?

❑Always Present, always the same intensity (76%-100%)
❑ Usually Present, but have short periods without pain (26%-50%)
❑ Always Present, Intensity varies (51%-75%)
❑ Often Present, but I am pain free for most of the day (1%-25%)

Do any of the following make your pain feel worse? (Check all that apply) ❑Work ❑Bending ❑Exercise/Sports
❑Lifting ❑Lying Down ❑Sitting ❑Standing ❑Sit to Stand ❑Twisting ❑Walking
❑ Stairs ❑ Can't find a comfortable position ❑ Other:_____

Does any 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

Does this pain radiate anywhere? ❑ Yes ❑No Where? _____

Please circle YES or NO for the following questions and answer appropriately:

Have you seen any other Doctors for the condition? What treatment was rendered? NO YES
_____
_____

Have you tried any medications such as anti-inflammatory or Prescription Painkillers
for your complaint? If yes, what kind of medication? what side effects? NO YES
_____

Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
If yes: When? For how long? What kind?
_____

Have you previously had any recent imaging (MRI, CT, Xray) taken within the last 12 months? NO YES
If yes:
Type of Imaging:_____Date of Exam:_____
Facility Performed:_____Phone:_____

Medications you are currently taking (**Include over the counter, herbal, and natural remedies with dosage and frequency**):

_____ _____ _____

_____ _____ _____

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

Allergy	Reaction

Who is your primary care physician? (doctor and/or practice) _____

Please list any surgical history:

_____ _____ _____

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
- ☐ Earache R or L
- ☐ Decreased Hearing
- ☐ 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

Back
- ☐ Pain
- ☐ Stiffness
- ☐ Tenderness

Joints:(circle) hips, knees, feet, shoulder, elbow, hands
- ☐ Aching
- ☐ Arthritis
- ☐ Limitation of joint movement
- ☐ Redness
- ☐ Morning Stiffness
- ☐ Swelling
- ☐ Tenderness

Muscles
- ☐ Aches
- ☐ Weakness

Neurological
- ☐ No symptoms
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Paralysis/Paresis
- ☐ Disorientation
- ☐ Vertigo/spinning
- ☐ Unsteadiness
- ☐ Dizziness

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

Endocrine
- ☐ No symptoms
- ☐ Cold intolerance
- ☐ Excessive Sweating
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Hot flashes

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

Pulmonary
- ☐ No symptoms
- ☐ Cough
- ☐ Asthma
- ☐ Pain with exertion

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

_____

_____

_____

_____

Past Medical History

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

Musculoskeletal:
- ☐ Shoulder injury
- ☐ Elbow injury
- ☐ Carpal Tunnel
- ☐ Knee injury
- ☐ Hip injury
- ☐ Joint Replacements

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

Endocrine:
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Thyroid disease
- ☐ Cushing's Disease
- ☐ Grave's Disease
- ☐ Addison's Disease

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

Heme/Oncology:
- ☐ Cancer: _____

Cardiovascular:
- ☐ High Blood Pressure/HTN
- ☐ Vascular Disease
- ☐ Pacemaker

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

Gastrointestinal:
- ☐ GERD
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Gall Bladder
- ☐ Gluten Sensitivity

Rheumatology:
- ☐ Osteoarthritis: Location:_____
- ☐ Rheumatoid arthritis
- ☐ Arthritis (unknown)
- ☐ Osteoporosis
- ☐ Gout
- ☐ Ankylosing spondylitis
- ☐ 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 nursing a child? ❑ Yes ❑ No

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

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 ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following?:

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 illegal 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

*******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 SOLIS APARTMENT 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 Solis 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 Solis 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 Solis 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 Solis 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 your 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 Solis Leasing office on your right facing interior of complex. Enter at sign for Atlanta Spine and Wellness.