ATLANTA SPINE & WELLNESS HEALTHY LIVING

Confidential Automobile 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!

Printed Name: _____ Date: _____

1. Do you have auto insurance? YES / NO
2. Who is the policy holder? _____
3. Are the premiums paid? YES / NO
4. Have you treated anywhere else for this auto case?
    - Ambulance? YES / NO
    - Emergency room? YES / NO
    - Doctor's office? YES / NO
    - Physical therapy? YES / NO
    - MRI/CAT scan? YES / NO
    - Other? YES / NO

      _____
5. Please provide a copy of your Declaration Page for proof of policy limits to understand coverage.
6. Do you have health insurance? YES / NO
7. Do you have an attorney? YES / NO

Signature of person completing questionnaire: _____

ACCIDENT HISTORY REPORT

Name: _____

Address:_____

Date of Accident: _____

Employer: _____ Occupation: _____

Social Security #: _____ Date of Birth: _____

Referred by:

Person: _____

Doctor: _____

Attorney: _____

At-fault party's Insurance Carrier: _____

Claim #: _____ Name of Rep: _____

Personal Auto Insurance Carrier: _____

Claim #: _____ Name of Rep: _____

Health Insurance Carrier: _____

Member #: _____ Group #: _____

HISTORY

❑ Driver ❑ Passenger (❑ front ❑ rear seat) ❑ Pedestrian ❑ Other: _____

❑ Traveling ❑ Stopped – facing: ❑ North ❑ South ❑ East ❑West

Location: Street _____City, State _____

DESCRIPTION OF ACCIDENT (check or circle appropriate description)

❑ Stopped facing down for (traffic / red light / stop sign)
and was struck in the rear by another vehicle

❑ Was pushed into the vehicle in front of his/hers

❑ Slowing down to execute a turn and was struck in the rear by another vehicle

❑ Was side swiped by another vehicle traveling in the same direction

❑ Another vehicle traveling in the opposite direction collided head-on with the vehicle in which he/she was riding

❑ Another vehicle traveling in the opposite direction suddenly turned in front of his/her vehicle causing the two vehicles to collide

❑ Another vehicle made an improper turn and caused the two vehicles to collide

❑ Another vehicle ran a (red light / stop sign)
and struck his/her vehicle (broadside / in the rear / in the front end)

❑ The vehicle in which he/she was riding was stuck by another vehicle
causing it to (spin around / roll over)

❑ The patient was involved in a multi-car collision

❑ The patient was involved in a motor vehicle collision

❑ The driver of vehicle that he/she was riding in lost control and
(struck another vehicle / ran off the road / struck an object: _____)
❑ The patient was thrown from the car to the pavement
❑ The patient injured his/her back in a lifting accident
❑ The patient was (a pedestrian / riding a bicycle / riding a motorcycle)
and was struck by a motor vehicle
❑ Other(Brief Description): _____
_____

Was the patient wearing a seat belt? Yes No
Did he/she strike any object inside the car? Yes No
Select the objects that were struck:

❑ Windshield	❑ Rear window of pick-up	❑ Dashboard
❑ Headrest	❑ Back of seat	❑ Seat broke
❑ Steering wheel	❑ Doorframe	❑ Rear view mirror
❑ Side window	❑ Jarred or was thrown about	❑ Dazed, can't recall

Select from the following list, the part or parts of the body that struck the object:
❑ Head ❑ Face ❑ Chest ❑ Neck ❑ Back ❑ Shoulder(s) (Rt / Lt)

❑ Arms (Rt / Lt)	❑ Elbow(s) (Rt / Lt)	❑ Wrist(s) (Rt / Lt)
❑ Leg(s) (Rt / Lt)	❑ Knee(s) (Rt / Lt)	❑ Ankle(s) (Rt / Lt)

❑ Other_____

Was the patient: ❑ Unconscious ❑ Cut or Bleeding ❑ Neither

If applicable, indicate normal or abnormal sensations experience by the patient immediately following the accident:

❑ Felt no immediate pain	❑ Head pain (headache)
❑ Semiconscious state	❑ Mid back pain (Rt / Lt)
❑ Upper extremity pain (Rt / Lt)	❑ Pain began several hours after accident
❑ Pain began shortly after the accident	❑ Neck pain (Rt / Lt)
❑ Low back pain (Rt / Lt)	❑ Lower extremity pain (Rt / Lt)

❑ Other_____

Indicate the action taken by the patient immediately following the accident:
❑ Was taken to hospital by ambulance
❑ Went home and rested ❑ Went onto normal business
❑ Went home and (shortly after / later that night / the following morning) began to experience (neck / mid back / low back) pain
❑ Went home and later (drove / was driven) to _____ Hospital
❑ Patient doctored him/herself thinking the pain would go away
❑ Went to physician: _____
❑ Hospitalization – name of hospital: _____

Indicate method of delivery to hospital:
❑ Ambulance ❑ Patient drove him/herself ❑ Driven by spouse/relative/friend/employer
❑ Went home and was later taken or drove self ❑ Not Applicable

Was the patient seen in the emergency room? Yes No
Was the patient admitted to the hospital? Yes No

Indicate any procedures performed at the hospital (including emergency room):
❑ Examination ❑ Stitches ❑ X-rays ❑ Physiotherapy
❑ Prescription ❑ Cervical Collar ❑ Injection ❑ Wounds dressed
❑ Complete bed rest ❑ Other_____
Follow his/her release from the hospital, the patient:
❑ Returned home and took it easy
❑ Returned home and went to bed
❑ Returned home and returned to the emergency room after ____ hours / _____ days
❑ Returned to work

Who was the first physician consulted? ❑ Family physician ❑Chiropractor ❑ Walk-in Clinic
When did the patient first contact a physician? ❑ Within a few days ❑Other_____
*If the patient contacted this office first, skip to Past History

What was done? (check all that apply)
❑ Examined ❑ X-rayed ❑ Prescription ❑ Physical Therapy ❑ Manipulation

Was the patient seen elsewhere for physiotherapy? Yes No
If yes, where did the patient receive these treatments? _____

Was the patient referred to any other physician or sent for any special diagnostic tests or examinations? ❑ Yes ❑ No If yes, please explain: _____

❑ MRI ❑ CT Scan ❑ EMG ❑ NCS ❑ SSEP ❑ Thermography

How long was the patient under the care of his/her physician? _____

Is the patient still under the doctor's care? Yes No

If no, when was the patient discharged? _____

If yes, indicate the frequency of the patient's visits to the doctor: _____

Other pertinent information:

_____

_____

PAST HISTORY

Has the patient been involved in any previous accidents or injuries of any kind? Yes No

If yes, please provide dates and details:

_____

_____

_____

Has the patient been previously treated for neck or back problems? Yes No

If yes, please provide dates and details:

_____

_____

Has the patient been previously treated by a chiropractor? Yes No

If yes, please provide dates and details:

_____

_____

_____

Past surgical history or any condition that could affect present condition:

_____

_____

_____

Any significant medical problems? (Diabetes, heart, lungs, etc.)

_____

_____

_____

Did the patient enjoy good health prior to this accident? Yes No

If no, please explain:

_____

_____

_____

PRESENT COMPLAINTS

What are the patient's present complaints? (begin with most severe)

_____

_____

_____

_____

DISABILITY

Has the patient lost any time from work since the accident? Yes No
If yes, number of days lost: _____

Is the patient still off from work? Yes No
If no, indicate the date the patient returned to work: _____

Is the patient working at this time? Yes No

Is the patient working with any restriction? Yes No
If yes, what are the restrictions?

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

_____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident.*

☐ I go to work but work in pain
☐ I limit my work activities
☐ Bending at work hurts
☐ Stooping at work hurts
☐ Sitting at work hurts
☐ Using the Computer at work hurts
☐ Pushing at work hurts
☐ Pulling at work hurts
☐ Kneeling at work hurts
☐ I have lost status at my company
☐ I have lost job security
☐ I didn't get a promotion
☐ I don't enjoy work as much as before
☐ I doze off at work
☐ I take unpaid time off work to go to Dr.
☐ I daydream at work more than before
☐ I feel tired at work
☐ I work in pain because I have bills to pay
☐ I can't take time off work b/c I would lose my job
☐ I keep working so I don't lose status at my company
☐ My business would fail if I took time off
☐ I believe in working even when I'm in pain
☐ I feel obligated to work even though I'm in pain
☐ My business would lose money if I took time off
☐ My work is not as good as it was before accident
☐ My boss reprimanded me for poor performances
☐ I got a different job within the same company
☐ I got a different job at another company
☐ I make less money than before the accident
☐ I cannot do the same work/job as before accident
☐ I can't concentrate as well at work
☐ I take paid time off to go to Dr.
☐ I make mistakes at work I didn't used to
☐ I hide my poor performance from my boss
☐ _____
☐ _____

Please check all that apply to your HOME/DOMESTIC duties *because of the accident*

☐ My house is not as clean now
☐ My yard is not as neat now
☐ My garden is not as productive now
☐ I do yard work, but do it in pain
☐ I cannot do my normal yard work
☐ I do house work, but I do it in pain
☐ I cannot do my normal housework
☐ Doing laundry hurts me
☐ I cannot do laundry now
☐ Washing dishes hurts me
☐ I cannot was dishes now
☐ Vacuuming hurts me
☐ I cannot vacuum now
☐ Cooking hurts me
☐ I cannot cook now
☐ Washing the car hurts me
☐ I cannot wash my car
☐ I cannot take time off due to children
☐ I have _____ children, ages _____
☐ I have to hire a paid housekeeper
☐ I asked someone for unpaid housekeeping help
☐ I had to hire a paid gardener
☐ I asked someone for unpaid yard work help
☐ Mowing the lawn hurts me
☐ I cannot mow the lawn
☐ Taking out the trash hurts me
☐ I cannot take out the trash
☐ I do not enjoy my gardening/yard work like I used to
☐ I do not enjoy my housework like I used to
☐ Gardening hurts me
☐ I cannot do my gardening at all since the accident
☐ Others living with me do my share of the work now
☐ Others living with me do my share of the yard work
☐ Others living with me do my share of the gardening
☐ _____
☐ _____

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (Part 1 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident*

☐ My exercise was affected by this crash
☐ I got to the gym and workout in pain
☐ I not longer go to the gym to workout
☐ I run but in pain
☐ I no longer run
☐ I take walks & have pain while walking
☐ I no longer take walks
☐ I use to make income at sports
☐ I have lost sports income since crash
☐ I am an amateur athlete
☐ I am a professional athlete
☐ I have gained ___ pounds since the accident
☐ I had to quit my _____ team after the accident
☐ _____
☐ I had to quit my _____ team after the accident
☐ I had to quit my _____ team after the accident
☐ I had to quit my _____ team after the accident
☐ I don't enjoy the sport of _____ anymore.
☐ I didn't enjoy the sport _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore.
☐ I didn't enjoy the sport _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore.
☐ I didn't enjoy the sport _____ for ____ weeks
☐ I don't enjoy the sport of _____ anymore.
☐ I didn't enjoy the sport _____ for ____ weeks

Please check all that apply to your HOBBY Activity *because of the accident*

☐ My hobbies were affected by accident
☐ Hobby #1_____
☐ I can't do Hobby #1 anymore
☐ I do Hobby #1 but in pain
☐ I have lost money from not doing #1
☐ Hobby#2_____
☐ I can't do Hobby #2 anymore
☐ I do Hobby #2 but in pain
☐ I have lost money from not doing #2
☐ Hobby#3_____
☐ I can't do Hobby #3 anymore
☐ I do Hobby #3 but in pain
☐ I have lost money from not doing #3
☐ Hobby #4_____
☐ I can't do Hobby #4 anymore
☐ I do Hobby #4 but in pain
☐ I have lost money from not doing #4
☐ _____

Please check all that apply to your TRAVEL Activity *because of the accident*

☐ Business travel was affected by crash
☐ Pleasure travel was affected by crash
☐ I hurt driving my own car
☐ I am in too much pain to drive
☐ I hurt when I am passenger in a car
☐ I am in too much pain to sit in a car
☐ I have anxiety when I'm in a car
☐ I hurt when I'm on an airplane
☐ I am in too much pain to travel by plane
☐ Travel Plan #1_____
☐ I did not go on travel plan #1
☐ I went, but did not enjoy #1 as much
☐ I went and the accident had no effect on #1
☐ Travel Plan #2_____
☐ I did not go on travel plan #2
☐ I went, but did not enjoy #2 as much
☐ I went and the accident had no effect on #2

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (Part 2 of 2)

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident*

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on a shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting in a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending a the waist
- ☐ Sitting in a movie theater
- ☐ Exercising
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the truck on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after bath or shower
- ☐ Life has become a chore just doing normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident*

- ☐ School was affected by this accident
- ☐ I am a student at _____
- ☐ I am in the _____year/grade
- ☐ I was: full time/ part time (circle one)
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain caring my school books
- ☐ I hurt sitting in class more than ___ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

The Oswestry (Low Back) Questionnaire

Name: _____ Today's Date: _____

Please read carefully:
This questionnaire has been designed to give the doctor information as to how your low back pain has affected you ability to manage everyday life. Please answer every section, and mark in each section only the ONE BOX which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please mark the one box which most closely describes your problem.

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain and I do not use them.

Section 2 – Personal Care
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but can manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift of carry anything at all.

Section 4 – Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me sitting more than ½ hour.
- ☐ Pain prevents me sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 – Social Life
- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys less than 30 minutes.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

Other Comments:

Score:
____ / ____

Neck Disability Questionnaire

Name: _____ Today's Date: _____

Please read carefully:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected you ability to manage everyday life. Please answer every section, and mark in each section only the ONE BOX which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please mark the one box which most closely describes your problem.

Section 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but can manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift of carry anything at all.

Section 4 – Reading
- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 – Driving
- ☐ I can drive without any neck pain.
- ☐ I can drive as long as I want with slight pain in my neck.
- ☐ I can drive as long as I want with moderate pain in my neck.
- ☐ I cannot drive as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-4 hours sleepless).
- ☐ My sleep is completely disturbed (4-5 hours sleepless).

Section 10 – Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.

Other Comments:

Score:
____ / ____

Personal Injury Financial Policy

1. If an attorney represents you:

   You must provide us with their name and address prior to receiving services.

   They must sign and fax a lien within 24 hours of your initial visit in this office.

   You must provide us with the following three insurances:

   A. Personal Health Insurance
   B. Medical Pay Insurance (your auto insurance)
   C. Liability Auto Insurance (person who hit you)

2. In an attorney does not represent you:

   You must sign a lien assigning payments for our services directly to us from your insurance carrier(s) prior to receiving services.

   You must provide us with the following three insurances:

   A. Personal Health Insurance
   B. Medical Pay Insurance (your auto insurance)
   C. Liability Auto Insurance (person who hit you)

3. If you are an existing patient, any treatment plan or financial agreement will be suspended until you have reached maximum medical improvement from your personal injury claim.

***Regardless of whether or not you have an attorney, if you do not have insurance, you will be considered a cash patient and will be expected to pay for services at the time they are rendered.**

I have read and agree to the above terms.

_____

Patient Signature Date

Health Ins ❑

Liability Ins ❑

Med-Pay Ins ❑

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

One disturbance to the nervous system is called a vertebral Subluxation. This occurs when one of more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by chiropractic adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral Subluxation. Our chiropractic method of correction is by specific adjustments or the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as rehabilitative procedures may be included.

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care professional.

All questions regarding the doctor's objective pertaining to may care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor/child:

I, _____ being the parent of legal guardian of _____
Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____	_____	_____
Print Name	Signature	Date

DIRECTIONS

*******PLEASE NOTE THAT GPS DEVICES RECOGNIZE 7100 PEACHTREE DUNWOODY AS THE NORTH SPRINGS MARTA STATION. WE ARE LOCATED ON THE OPPOSITE SIDE, 500 FEET FURTHER NORTH ON PEACHTREE DUNWOODY. WE ARE A SINGLE BRICK BUILDING SEPARATE FROM THE 7000 BUILDINGS AND ACROSS THE STREET FROM 7150 DUNWOODY STATION APARTMENTS.*******

FROM I-75N: *TAKE 285E TO 400N. TAKE EXIT 5A (DUNWOODY) AND VEER TO THE RIGHT. AT THE FIRST INTERSECTION (PEACHTREE DUNWOODY), MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES. YOU WILL PASS THE NORTH SPRINGS MARTA STATION ON THE LEFT AT THE SECOND TRAFFIC LIGHT. PASS THE 7000 BUILDING ON THE RIGHT. 7100 PEACHTREE DUNWOODY RD WILL BE ON THE RIGHT HAND SIDE. FIND SUITE 110 ON THE LOWER LEVEL RIGHT (SOUTH) SIDE OF THE BUILDING*

FROM I-285 EAST: *TAKE EXIT 28 PEACHTREE DUNWOODY ROAD AND VEER TO THE RIGHT. PASS NORTHSIDE HOSPITAL AND CHILDREN'S HOSPITAL OF ATLANTA ON YOUR LEFT. CONTINUE NORTH ON PEACHTREE DUNWOODY ROAD. WE ARE LOCATED ON THE RIGHT AT 7100 IN A SINGLE BRICK BUILDING.*

FROM I-285 WEST: *TAKE EXIT GA 400 NORTH. TAKE EXIT 5A (DUNWOODY). AT THE FIRST INTERSECTION (PEACHTREE DUNWOODY),MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES. WE ARE LOCATED ON THE RIGHT AT 7100 IN A SINGLE BRICK BUILDING.*

FROM I-85 NORTH: *TAKE 85 SOUTH TO I-285 WEST. TAKE 400 NORTH EXIT. TAKE EXIT 5A (DUNWOODY) AT THE FIRST INTERSECTION (PEACHTREE DUNWOODY),MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES. YOU WILL PASS THE NORTH SPRINGS MARTA STATION ON THE LEFT AT THE SECOND TRAFFIC LIGHT. PASS THE 7000 BUILDING AND 7100 PEACHTREE DUNWOODY RD IS ALSO ON THE RIGHT.*

FROM 75/85 SOUTH (DOWNTOWN): *TAKE 75/85 NORTH. CONTINUE ON 85 NORTH AT THE SPLIT. TAKE GA 400 EXIT TO THE TOLL. FROM 400 NORTH, TAKE EXIT 5A TO DUNWOODY. AT THE FIRST INTERSECTION (PEACHTREE DUNWOODY), MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES TO 7100.*

FROM NORTH SPRINGS MARTA STATION: *CROSS AT THE LIGHT SO THAT YOU ARE ON THE OPPOSITE SIDE OF THE STREET. TURN LEFT AND CONTINUE ON PEACHTREE DUNWOODY ROAD FOR APPROXIMATELY 500 FT AND OUR OFFICE WILL BE ON YOUR RIGHT AT 7100 PEACHTREE DUNWOODY ROAD.*