

Atlanta Spinal Correction Center

Patient Information

Thank you for choosing the Atlanta Spinal Correction Center for your chiropractic needs. Please completely fill in the following information to the best of your ability. This will assist us in helping you. If you have any questions or concerns, please do not hesitate to ask.

(Please Print Clearly)

Name _____ Date _____ S/S# _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work/Cell Phone _____ Sex M F D.O.B. _____ Age _____
E-Mail Address: _____
Are you: Minor Single Married Divorced Widowed Separated
Your Employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouse's or Parents Name _____ Work Place _____ Work Phone _____
Names and ages of children _____ Referred to this office by _____
Person to contact in case of emergency _____ Relation _____ Phone # _____

Insurance Information

(Please present your insurance card upon completion of this form)

Who will be responsible for this account? You Spouse Health Ins Auto Ins Other
Name of Insured _____ Relationship to Patient _____
Insured D.O.B. _____ Insured S/S # _____ Effective Date _____
Name of Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone # (____) _____
Policy Number _____ Group # _____
Primary Care Physician (MD) _____ MD's phone # _____

Current Health Condition

Health Condition That You Are Here For _____
Other Doctors Seen for This Condition _____
Type of Treatment _____ Results _____
When Did This Treatment Begin? _____ Has This Occurred Before? Yes No
Is Condition: Job Related Auto Accident Home Injury Fall Other _____
Are You Currently Taking Any Medications? _____

Past Health History

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia
 Back Surgery Broken Bones Other _____
Major Accidents or Falls _____
Hospitalization _____

(Please Complete Other Side)

Check Any Of The Following You Have Had In The Past 6 Months:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urination

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- General Stiffness
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Colitis

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/ Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain
- Breast Pain/Lumps
- Prostate Dysfunction
- Sexual Dysfunction
- Other Problems

FEMALES ONLY

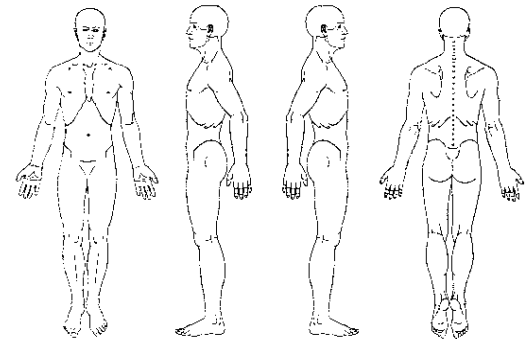
When was your last period? _____

Is there ANY possibility that you may be pregnant?
 Yes No Not Sure

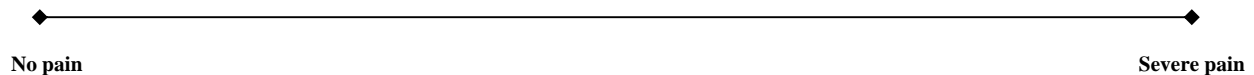
DESCRIPTION & LOCATION OF PAIN

Please mark the location of pain with the following descriptions:

R – Radiating **T** – Tingling **N** - Numbness



Place a mark at a place somewhere on the line corresponding to the level of pain for your chief complaint.



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Doctor's Office will prepare any necessary reports or forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to the Atlanta Spinal Correction Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered, if not covered by my insurance policy, are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. The patient also agrees that he/she is responsible for all bills incurred at this office. I hereby authorize the Doctor to treat my conditions as he or she deems appropriate.

Patient's Signature _____
 Consent to Treat a Minor _____
 Guardian Signature _____
 Of Authorizing Care _____

Date _____
 Date _____
 Date _____