

HOLLY SPRINGS

CHIROPRACTIC & MASSAGE

120 Hickory Rd.

Holly Springs, GA 30115

678-880-6616

Today's Date:

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

How did you hear about us?

Marital Status:

- Married Spouse's Name: _____
- Single
- Divorced
- Widowed

Friend who is a patient _____

- Internet Search Event
- Facebook Instagram
- Drive By
- Other: _____

Number of Children: _____ Ages: _____

Your Employer: _____ Occupation: _____

Who is responsible for your bill? Self Spouse Medicare Health Insurance Auto Insurance

Health Insurance Company: _____ Name of Primary: _____

Primary Date of Birth: _____ Primary SSN: _____

1. Reason for Chiropractic Care: _____

2. Is your condition: the result of an accident of injury? Work Auto Other _____
 a worsening long term problem?

3. Onset: When did you first notice your symptoms?

4. Intensity: How extreme are your symptoms?

1 5 10
 - - - - - - - - - - -
 Absent Painful Agonizing

5. Duration/Timing: When and how often do you feel it? Constant Sometimes

Worse in the: Morning Evening

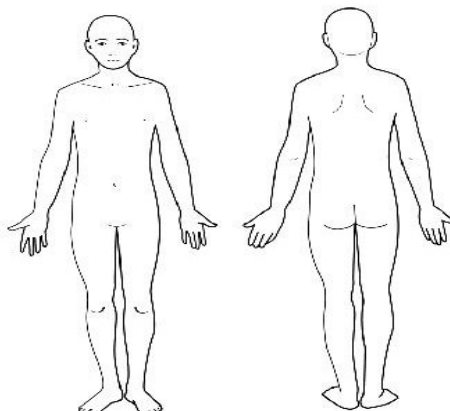
Better in the: Morning Evening

6. Quality of Symptoms: What does it feel like?

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramping
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location: Where does it hurt?
 X = current condition O= Past condition

8. Radiating: To what area does the pain radiate, shoot, or travel?



9. Aggravating/Relieving Factors: What makes it worse such as time of day, movement, or certain activities?

What worsens the problem?

What lessens the problem?

10. Prior Interventions: What have you done to relieve the symptoms?

- Medication Surgery Ice/Heat Acupuncture
 Homeopathic Remedies Chiropractic Physical Therapy Massage

11. What else should the doctor know about your condition?
12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household Chores: _____

Personal Interactions: _____

13. Review of Systems: Chiropractic care focuses on the integrity of your nervous system which controls and regulates you entire body. Please check beside any condition that you have NOW or had in the PAST.

Musculoskeletal

- | Now | Past |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Injuries |
| <input type="checkbox"/> | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> | <input type="checkbox"/> Arm Pain |
| <input type="checkbox"/> | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain |

Endocrine

- | Now | Past |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> | <input type="checkbox"/> Immune Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> | <input type="checkbox"/> Low Energy |

Neurological

- | Now | Past |
|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Headache |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> Pins/Needles |
| <input type="checkbox"/> | <input type="checkbox"/> Numbness |
- Digestive**
- | Now | Past |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> Food Sensitivities |
| <input type="checkbox"/> | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> Constipation or Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> Ulcerative Colitis |

Genitourinary

- | Now | Past |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> PMS Symptoms |

Cardiovascular

- | Now | Past |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> | <input type="checkbox"/> Angina |
| <input type="checkbox"/> | <input type="checkbox"/> Excessive Burning |

Sensory

- | Now | Past |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Ear Infections |
| <input type="checkbox"/> | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> | <input type="checkbox"/> Loss of Taste |

Constitutional

- | Now | Past |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> Sudden Weight Change |
| <input type="checkbox"/> | <input type="checkbox"/> Weakness |

Respiratory

- | Now | Past |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> Apnea |
| <input type="checkbox"/> | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> Pneumonia |

Integumentary

- | Now | Past |
|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> | <input type="checkbox"/> Acne |
| <input type="checkbox"/> | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> | <input type="checkbox"/> Rash |

Past, Personal, Family, and Social History

Please identify your past health history, including accidents, injuries, illnesses, and treatments

14. Illnesses

- | Now | Past | Now | Past | Now | Past | Now | Past | Now | Past | | |
|--------------------------|-----------------------------------|--------------------------|--|--------------------------|---------------------------------------|--------------------------|---|--------------------------|--------------------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Aids | <input type="checkbox"/> | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> Allergies | <input type="checkbox"/> | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> Mumps/Polio | <input type="checkbox"/> | <input type="checkbox"/> STD |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | <input type="checkbox"/> | <input type="checkbox"/> Other: _____ | | | | | | |

15. Surgery

- | Now | Past | Now | Past | Now | Past | Now | Past | | |
|--------------------------|---------------------------------------|--------------------------|---|--------------------------|------------------------------------|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> | <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> | <input type="checkbox"/> Elective Surgery: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> Spine | <input type="checkbox"/> | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____ | | | | | | | | |

16. Treatments

Check the ones you are receiving now or have in the past received.

Now Past

- Acupuncture
- Antibiotics
- Birth Control Pills
- Blood Transfusions
- Chemotherapy
- Chiropractic Care
- Dialysis
- Herbs
- Homeopathy
- Hormone Replacement
- Inhaler
- Massage Therapy
- Physical Therapy
- Nutritional Supplements
- _____
- Medications (list)
- _____
- _____
- _____

17. Injuries

Have you ever...

- Had a fracture or broken bone
- Had a spinal nerve disorder
- Been knocked unconscious
- Been injured in an accident
- Used a crutch or other support
- Used neck or back bracing
- Received a tattoo
- Had a body piercing

18. Family History

Please give the history of your immediate family members

Relative	State of Health		Illnesses
	Good/	Poor	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____

19. Are there any other hereditary health issues that you know about? _____

20. Lifestyle History

- Alcohol Use Daily Weekly How much? _____
- Coffee Use Daily Weekly How much? _____
- Tobacco Use Daily Weekly How much? _____
- Exercise Daily Weekly Type _____
- Water Daily Weekly How much? _____
- Vitamins Daily Weekly Type _____

Females: Is it possible that you are pregnant? Yes No
 First day of last cycle: _____

- 21. What is the primary stressor in your life? _____
- 22. In what position do you sleep most often? _____
- 23. What would be the most significant thing you could do to improve your health? _____
- 24. Do you have any specific health goals? _____
- 25. How much sleep do you get per night? _____
- 26. Do you drink a half gallon of water daily? Y N

27. Activities of Daily Living

How does your condition interfere with your ability to function?

	No Effect	Moderate Effect	Severe Effect		No Effect	Moderate Effect	Severe Effect
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grocery Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising out of chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Showering/Bathing self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking over shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation complex. It is important to each patient to understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express maximum health potential.

Patient Inform Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities of physical therapies and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/ or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, included but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/ her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Healthcare Authorization and Privacy Policy

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Holly Springs Chiropractic and Massage to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Holly Springs Chiropractic and Massage to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If Holly Springs Chiropractic and Massage contacts me by phone, I give them permission to leave a phone message on my answering or voice mail.
- I give permission to Holly Springs Chiropractic and Massage to use my testimonial written by me for marketing purposes, such as sharing with other patients or potential patients, in their brochures, on their website, or in ads in print media.
- I give Holly Springs Chiropractic and Massage permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with my doctor at any time in private the doctor will provide a room for these conversations.
- By signing this form I am giving Holly Springs Chiropractic and Massage permission to use and disclose my protected health information in accordance with the directives listed above.

The use of this format is intended to make my experience with Holly Springs Chiropractic and Massage's office more efficient and productive, as well as to enhance my access to quality health care and health information. This authorization will remain in effect for the duration of my care at Holly Springs Chiropractic and Massage, plus 7 years or until revoked by me.

AUTHORIZATION AND ASSIGNMENT—AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his/ her staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/ her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official at Holly Springs Chiropractic and Massage. The written notice must contain the following information: Your name, Social Security Number, a date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Holly Springs Chiropractic and Massage for its own use/disclosure of PHI. (*Minimum necessary standards apply*)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Holly Springs Chiropractic and Massage will not refuse to provide treatment however, it will not be possible for Holly Springs Chiropractic and Massage to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Holly Springs Chiropractic and Massage will be unable to contact me 3) all contact with Holly Springs Chiropractic and Massage regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form, the Right to Revoke Authorization Form, and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Holly Springs Chiropractic & Massage: Darren Surma, D.C., Oliver Evans, D.C., Mary Strange, D.C.

Social Security Number: XXX-XX-_____	Date of Birth:
Patient Name: (please print)	
Patient's signature (or parent or guardian):	Date:
Name of personal representative (if applicable)	
Description of representative's authority to act on patient's behalf:	
Representative's Signature:	Date: