

## Sandy Plains Chiropractic Clinic

2697 Sandy Plains Road  
Marietta, GA 30066

Phone 770.971.1355  
Fax 770.509.8559

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ City & State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ ( )M ( ) F S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status S M D W # of Children \_\_\_\_\_

Have you ever received a Chiropractic Adjustment? Y N When? \_\_\_\_\_ By whom? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

### YOUR HEALTH PROFILE:

The focus in our office is your health. Our goals are, first, to address the issues that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the changes that have occurred and ultimately may challenge your health potential.

Please circle when you experienced these stresses\*: C (child), T (teenager), A (adult), or N (not at all.)

#### PHYSICAL STRESS:

Birth Traumas (Forceps, Cesarean, breach, with drugs)	C	T	A	N	Explain: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Illnesses, Hospitalizations, or Surgeries	C	T	A	N	
Slips/Falls	C	T	A	N	
Car Accidents	C	T	A	N	
Sports Injuries	C	T	A	N	
Physical Abuse	C	T	A	N	
Work Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Sitting on a wallet for years	C	T	A	N	
Sleeping Position – Stomach	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying a heavy purse/book bag/child	C	T	A	N	
Repetitive lifting/bending	C	T	A	N	
Driving for many hours	C	T	A	N	
Continuous hours sitting/standing	C	T	A	N	
Shoveling/Painting/Gardening/Cleaning	C	T	A	N	

#### CHEMICAL STRESS:

Smoker – Amount?	C	T	A	N	_____ _____ _____ _____ _____
Alcohol –Amount?	C	T	A	N	
Caffeine – Amount?	C	T	A	N	
Excessive Sugar / Artificial Sweeteners	C	T	A	N	
Prolonged use of medication (e.g. antibiotics, inhalers)	C	T	A	N	

#### EMOTIONAL STRESS:

Relationships	C	T	A	N	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Career	C	T	A	N	
Children	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Hold in Feelings	C	T	A	N	
Quick Tempered	C	T	A	N	
Verbal Abuse	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Loss of a loved one	C	T	A	N	

\*Survey from Mager & Associates Consulting

Please describe briefly what brought you to our office today. What is your chief complaint? Please comments/describe your symptoms (i.e. when did it start and was there any initiating factor you can think of?) \_\_\_\_\_

Does anything make it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Is the pain sharp? Y N Dull? Y N Comes and goes? Y N Travels/radiates? (Where) Y N Getting worse? Y N Getting better? Y N  
Has a similar problem occurred before? Y N If so, when? \_\_\_\_\_ Your actions then? \_\_\_\_\_  
Does it interfere with work? Y N Sleep? Y N Sitting? Y N Hobbies? Y N Leisure? Y N Other? \_\_\_\_\_

Please list any other doctors (including chiropractors) seen for this problem and when: \_\_\_\_\_

List any medications or supplements you are taking: \_\_\_\_\_

Any allergies? \_\_\_\_\_

Please mark "1" for current symptoms, "2" for symptoms in the last 6 months, and "3" if you have ever experienced the following:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Pins/Needles in legs	<input type="checkbox"/> Fainting	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Pin/Needles in arms	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Ears ringing	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of taste
<input type="checkbox"/> Irritated stomach	<input type="checkbox"/> Weight changes	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Irritability	<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Tension
<input type="checkbox"/> Rashes/Eczema	<input type="checkbox"/> Problems sleeping	<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Respiratory problems	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Fever	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Urination problems	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Menstrual cramping	<input type="checkbox"/> Menstrual irregularity	<input type="checkbox"/> Hernias	<input type="checkbox"/> Infertility	<input type="checkbox"/> Visual impairment	
<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Hearing impairment				

On a scale of poor, good, or excellent, please describe your:

Diet \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_

On a scale of 1-10, describe your stress level (1= none, 10 = extreme): Occupational \_\_\_\_\_ Personal \_\_\_\_\_

Is there a family history of:  Heart Disease/Stroke?  Arthritis?  Cancer?  Diabetes?  Other?

#### FAMILY HEALTH PROFILE

We are also interested in the health and well-being of your family and loved ones. Please share any health concerns and conditions.

Spouse: \_\_\_\_\_  
Children: \_\_\_\_\_  
Parents: \_\_\_\_\_  
Siblings: \_\_\_\_\_  
Others: \_\_\_\_\_

The statements made on this form are accurate to the best of my recollection, and I agree to allow this office to examine me for further evaluation and treatment. I consent to have Sandy Plains Chiropractic Clinic file my insurance if applicable, and have the insurance company pay this clinic directly for services rendered. I further agree that I am responsible for payment on my account regardless of what my insurance company pays.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Sandy Plains Chiropractic Clinic, 2697 Sandy Plains Road, Marietta, GA 30066**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I understand and have been provided with a *Notice of Information Practices* (posted next to front desk in hallway), that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Informed Consent and terms of acceptance for Chiropractic Care**

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.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

A subluxation is misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function between the brain and tissues of the body. An adjustment is the specific application of forces to the subluxated area to facilitate the body's correction. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. We do this by detecting and correcting vertebral subluxations with a chiropractic adjustment.

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I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Patient or legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature (office staff)

\_\_\_\_\_  
Date

## OFFICE POLICY

Sandy Plains Chiropractic Clinic is served by a highly dedicated staff. Our objective is enhancing health by providing unique, cost-effective care. Clearly defining our office policies allows both patient and doctor to concentrate on regaining and maintaining optimum health. Another objective is to eliminate a major interference to the expression of the body's innate wisdom.

Appointments are requested; walk-ins are welcome, but seen after scheduled patients. If late, you may have to wait for the next available opening. We do attempt to honor all appointments at the scheduled time.

X-rays will be part of your examination if existing ones are more than two years old.

Massage therapy/Neuromuscular therapy may be part of the healing process. It is necessary to collect 50% of the neuromuscular therapy fee (massage) at the time of service. Twenty-four hour cancellation is a must or you, the patient, will be charged.

Please – no food or drink in the clinic. Also, please turn off cell phones in the clinic.

## FINANCIAL POLICY

Payment is expected when services are rendered, unless previous arrangements are made. We accept cash, checks, Visa, MasterCard, and Discover. There will be a \$25 fee for any returned checks. We will file insurance while patients are under reactive care. Wellness care quotes are available upon request. Insurance is filed as a patient courtesy; it is the patient's final responsibility for all charges incurred. Insurance contract discounts are not accepted for neuromuscular therapies.

**\*\*\*\*\*BCBS patients:** Keep in mind that often the check that we should be receiving from filing for our services is sent to you. Please bring or mail that check (reimbursed) or your own personal check for the same amount with a copy of the EOB (Explanation of Benefits) to us when you receive it.

I consent to Sandy Plains Chiropractic Clinic filing my insurance, and having the insurance company pay this clinic directly for services rendered.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

### Consent to evaluate and adjust a minor child

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_  
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### Pregnancy release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date