

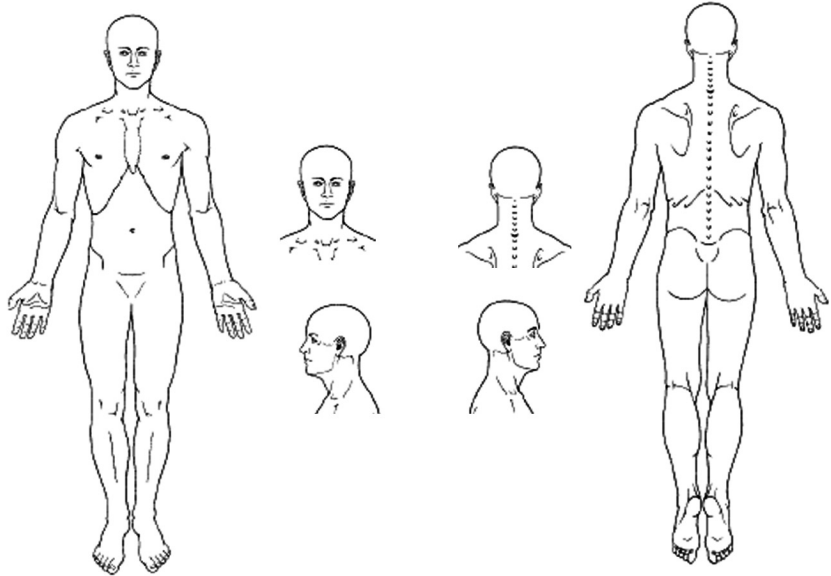
# Perkins Chiropractic Clinic

3232 Krisam Creek Drive, Suite 200, Loganville, GA 30052 | 678-957-6808

Date \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Male  Female Age \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home (\_\_\_\_) \_\_\_\_\_  
Work/Cell (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone (\_\_\_\_) \_\_\_\_\_  
 Single  Married  
Spouse's Name \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
How did you hear about us or who referred you?  
\_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Health Insurance \_\_\_\_\_  
Policy # \_\_\_\_\_

Mark the diagram with the following:

- X Pain
- O Burning
- Numbness or Tingling



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### In case of an emergency, contact:

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home (\_\_\_\_) \_\_\_\_\_

What is your major complaint? \_\_\_\_\_  
How long have you had this condition? \_\_\_\_\_  
Did it begin  Gradually  Suddenly  Progressive over time  
Have you had this or anything similar to this before? \_\_\_\_\_  
Do any positions make it feel better? Describe how \_\_\_\_\_  
Do any positions make it feel worse? Describe how \_\_\_\_\_  
Type of pain  Sharp  Dull  Ache  Burn  Throb  
Does the pain radiate in to your  Arm  Leg  Does not radiate  
Is this condition interfering with your  Work  Sleep  Daily Routine  Other  
Do you have numbness or tingling?  No  Yes  
How often do you experience these symptoms  100%  75%  50%  25%  10%  
What do you think caused this condition? \_\_\_\_\_  
Do you have any family members who suffer from the same complaint? \_\_\_\_\_ If so, who? \_\_\_\_\_  
Is the condition due to an accident?  No  Yes Date \_\_\_\_\_ Was it due to:  Auto  Work  Home  Other  
Rate the severity of your pain on a scale of 1 (least painful) to 10 (severe pain) \_\_\_\_\_  
Are there any other doctors that you have seen for this problem? The date(s) \_\_\_\_\_  
\_\_\_\_\_  
Who is your primary care doctor? \_\_\_\_\_

Mark the box next to any condition you have or have had in the past.

- |                                 |  |   |
|---------------------------------|--|---|
| <input type="radio"/> Allergies | <input type="radio"/> Diabetes           | <input type="radio"/> Reproductive Problems |
| <input type="radio"/> Arthritis | <input type="radio"/> Digestive Problems | <input type="radio"/> Migraine/Headaches    |
| <input type="radio"/> Cancer    | <input type="radio"/> Kidney Problems    | <input type="radio"/> Stroke                |
| <input type="radio"/> Dizziness | <input type="radio"/> Heart Conditions   | <input type="radio"/> Sinus Problems        |

Please list any other conditions or symptoms that are not listed above concerning your health history.

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EXERCISE

WORK ACTIVITY

HABITS

- |  |                                   |  |
|--|-----------------------------------|--|
| <input type="radio"/> None                 | <input type="radio"/> Sitting     | <input type="radio"/> Smoking _____ Packs/Day        |
| <input type="radio"/> Moderate Type _____  | <input type="radio"/> Standing    | <input type="radio"/> Alcohol _____ Drinks/Week      |
| <input type="radio"/> Daily Duration _____ | <input type="radio"/> Light Labor | <input type="radio"/> Coffee/Caffeine _____ Cups/Day |
| <input type="radio"/> Heavy                | <input type="radio"/> Heavy Labor | <input type="radio"/> High Stress Level _____        |

Have you ever been treated by a chiropractor  Yes  No Name \_\_\_\_\_ Date \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had

	Date	Description
Auto Accidents	_____	_____
Surgeries	_____	_____
Hospitalization	_____	_____
Falls	_____	_____
Broken Bones	_____	_____

Are you currently taking any medications  Yes  No Type \_\_\_\_\_

I hereby consent to the performance of the chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays. I further understand that in all healthcare, there are some risks involved. However, in chiropractic care the risks are minimal. I understand that at any point in my care I have the opportunity to discuss my care with the doctor. I understand that results are not guaranteed.

I assign Advanced Chiropractic Clinic P.C. direct payment of all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date