CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly

AC Spine & Wellness Center
217 Scenic Hwy.
Lawrenceville, GA 30046-5621
(770) 513-8922
www.acspineandwellness.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
◯ No ◯ Yes **When?**

Last Name

If so, whom?

First Name **Middle Name (or initial)**

Gender
◯ Male ◯ Female

If the patient is a minor child, print child's full name

Your Social Security Number

What source led you to us?

Birth Date (MM/DD/YYYY)

◯ **Healthline** ◯ **Our Town** ◯ **Newspaper** ◯ **Internet** ◯ **Sign**

◯ **Referral** ◯ **Other**

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Address

City **State/Province** **ZIP/Postal Code** **Home Phone**

Spouses's Name and Age

Email Address **Cell Phone**

Child's Name and Age

Your Employer **Your Occupation**

Child's Name and Age

Address

Child's Name

May we contact you at work?
◯ Yes ◯ No

City **State/Province** **ZIP/Postal Code**

Work Phone

Emergency Contact **Phone**

Insurance Carrier **Policy Number** **Primary Care Provider's Name**

Insured's Last Name **Birth Date (MM/DD/YYYY)**

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

First Name **Middle Name (or initital)**

Insured's Employer

Address

City **State/Province** **ZIP/Postal Code** **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

1. **The symptoms that have prompted me to seek care today include:** _____

- ◯ Headaches
- ◯ Neck pain
- ◯ Back pain
- ◯ Nervousness
- ◯ Tension
- ◯ Other _____
- ◯ Ears ringing/buzzing
- ◯ Ear infection
- ◯ Pins/needles in arms
- ◯ Numbness in fingers
- ◯ Numbness in toes
- ◯ Lights bother eyes
- ◯ Fainting
- ◯ Head seems heavy
- ◯ Bedwetting
- ◯ Sinus infection
- ◯ Loss of memory
- ◯ Loss of smell
- ◯ Loss of balance
- ◯ Loss of taste
- ◯ Fever

Patient name

2. And are the result of (darken circle): ◯ **An accident or injury**

◯ Work ◯ Auto ◯ Other_____

◯ An interest in: ◯ Wellness ◯ Other_____

3. Intensity (Please rate your current symptoms/pain.) *Please circle.*

0 1 2 3 4 5 6 7 8 9 10
Absent — Uncomfortable — Agonizing

4. Duration and Timing (How often do you experience symptoms?)

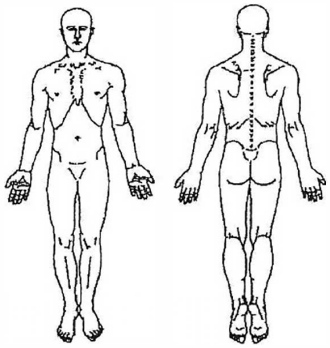
0 1 2 3 4 5 6 7 8 9 10
None — Comes/goes — Most of the time — Constant

When did symptoms begin? _____

5. Quality of symptoms
(What does it feel like?)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other_____

6. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



7. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

8. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem?_____

What tends to lessen the problem?_____

9. Prior interventions (What have you done to relieve the symptoms?)

- ◯ Prescription medication
- ◯ Over-the-counter drugs
- ◯ Homeopathic remedies
- ◯ Physical therapy
- ◯ Surgery
- ◯ Acupuncture
- ◯ Chiropractic
- ◯ Massage
- ◯ Ice
- ◯ Heat
- ◯ Other_____

10. What else should AC Spine & Wellness know about your current condition? _____

11. How does your current condition interfere with your:

Work or career: _____

Recreational activities_____

Household responsibilities_____

Personal relationships_____

Consultation Notes

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

12. Injuries
Have you ever:

- ◯ Had a fractured or broken bone
- ◯ Had a spine or nerve disorder
- ◯ Been knocked unconscious
- ◯ Used a crutch or other support
- ◯ Used neck or back bracing
- ◯ Received a tattoo
- ◯ Had a body piercing

13. Operations
Surgical interventions, which may or may not have included hospitalization.

- ◯ Appendix removal
- ◯ Bypass surgery
- ◯ Cancer
- ◯ Cosmetic surgery
- ◯ Elective surgery: _____ _____
- ◯ Eye surgery
- ◯ Hysterecotmy
- ◯ Pacemaker
- ◯ Spine_____ _____ _____
- ◯ Tonsillectomy
- ◯ Vasectomy
- ◯ Other:_____ _____

Most recent: Exam/Physical _____ MO / YR

Most recent: Blood Work Tested _____ MO / YR

14. Treatments
Check the ones you've received in the **Past** or are receiving **Currently.**

Past	Currently	
◯	◯	Acupuncture
◯	◯	Antibiotics
◯	◯	Birth control pills
◯	◯	Blood transfusions
◯	◯	Chemotherapy
◯	◯	Chiropractic care
◯	◯	Dialysis
◯	◯	Herbs
◯	◯	Homeopathy
◯	◯	Hormone replacement
◯	◯	Inhaler
◯	◯	Massage therapy
◯	◯	Physical therapy

Past ◯ Currently ◯ Nutritional Supplements
List_____

Past ◯ Currently ◯ Medications (prescription and over-the-counter):
List_____

Past ◯ Currently ◯ Allergies
List_____

Doctor's Initials

AC Spine & Wellness

(Continued from previous page)

18. Family History
Some health issues are hereditary. Tell AC Spine & Wellness about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

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

20. Social History
Tell us about your health habits and stress levels.

SOCIAL

Alcohol use ○ Daily ○ Weekly How much? _____
Coffee use ○ Daily ○ Weekly How much? _____
Tobacco use ○ Daily ○ Weekly How much? _____
Exercising ○ Daily ○ Weekly How much? _____
Pain relievers ○ Daily ○ Weekly How much? _____
Soft drinks ○ Daily ○ Weekly How much? _____
Water intake ○ Daily ○ Weekly How much? _____
Hobbies _____

Prayer or meditation? ○ Yes ○ No
Job pressure/stress? ○ Yes ○ No
Financial peace? ○ Yes ○ No
Vaccinated? ○ Yes ○ No
Mercury fillings? ○ Yes ○ No
Recreational drugs? ○ Yes ○ No

21. Activities of Daily Living
Which activities aggravate your symptoms?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Gettiing in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Carrying Groceries	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Sleeping	○	○	○	○
Working	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____ **23. How much sleep do you average per night?** _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____ **25. What is your preferred sleeping position?** _____

26. Describe your typical eating habits: ○ **Skip breakfast** ○ **Two meals a day** ○ **Three meals a day** ○ **Snacking between meals**

What do you typically eat for: Breakfast _____ **Lunch** _____ **Dinner** _____

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Signature _____ Date (MM/DD/YYYY) _____

Consultation Notes

Patient name _____

Doctor's Initials _____

AC Spine & Wellness