

PATIENT INFORMATION

Date: _____

Last Name First Name Middle Name

Address _____

City State Zip

Email Address: _____

Cell (____) _____ Home (____) _____

Work (____) _____ SS# _____

Date of Birth ____/____/____ Age ____ Gender: M F

Height _____ Weight _____ Married Widowed Single

Who is responsible for account? _____

In case of emergency please contact:

Name: _____ Phone (____) _____

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber's Name _____

Relationship to Patient _____

Subscriber's Employer _____

Member # _____ Group # _____

Subscriber's DOB ____/____/____ SS# _____

Secondary Insurance Company _____

Subscriber's Name _____

Relationship to Patient _____

Subscriber's Employer _____

Member # _____ Group # _____

Subscriber's DOB ____/____/____ SS# _____

INSURANCE PAYMENTS SENT DIRECTLY TO PATIENTS

Should your insurance company send direct reimbursements to you for services rendered at Complete Healthcare Medical Center, P.C., please do the following:

1. Endorse all checks
2. Either mail or bring to the clinic within 10 days of receipt of check
3. Include the Explanation of Benefits

I fully understand that if my insurance company sends me a check, I will submit it to Complete Healthcare Medical Center, P.C. within 10 days of receipt of payment. If I do not submit payment in full then I full understanding that I will be sent to collections. Patient Initial _____

How did you hear about our office:

____ I am a returning old patient ____ At my work (Company Name): _____

____ Savvy Shopper ____ MTM ____ Post Card ____ Big Deals ____ Internet ____ Gift Certificate ____ Walk-In

____ CHC Employee ____ Phone Marketing ____ Living Social Doctor: _____

Who may we thank: Patient Referral: _____ Attorney: _____

PROMOTION ACKNOWLEDGEMENT (if applicable)

Acknowledgement of FREE SERVICES I, _____, hereby certify that I have received a consultation and examination at no charge. I understand that any charges for additional services are my financial responsibility.

Signature

Date

Acknowledgement of Promotion Cost

Promotion Code: _____

Patient Initial _____

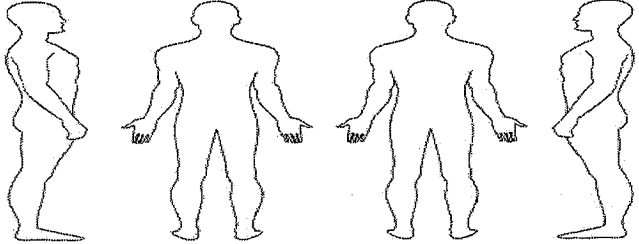
PATIENT INTAKE FORM

Patient Name: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation ☐ None

2. What is the reason for today's visit: _____

3. Indicate on the drawings below where you have pain/symptoms:

				<p>Please list your complaints in order from worst (1) to least (10).</p> <p>1. _____ 6. _____</p> <p>2. _____ 7. _____</p> <p>3. _____ 8. _____</p> <p>4. _____ 9. _____</p> <p>5. _____ 10. _____</p>	
Front		Back			

4. How often do you experience your symptoms:

- ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time) ☐ N/A
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

- ☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other: _____

6. How are your symptoms changing with time?

- ☐ Getting Worse ☐ Staying the Same ☐ Getting Better ☐ N/A

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

- 0 1 2 3 4 5 6 7 8 9 10 (Please circle) ☐ N/A

8. How much has the problem interfered with your work?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐ N/A

9. How much has the problem interfered with your social activities?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐ N/A

10. Who else have you seen for your problem(s)?

- ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Other _____
☐ Massage Therapist ☐ Physical Therapist ☐ No One

11. Have you had any x-rays taken of affected are(s)? ☐ NO ☐ YES if yes, list dates: _____

12. Have you had a MRI in the affected area(s)? ☐ NO ☐ YES if yes, list dates: _____

13. How long have you had this problem? _____

14. How do you think your problem began? _____

15. Do you consider this problem to be severe?

- ☐ Yes ☐ Yes, at times ☐ No

16. What aggravates your problem? _____

17. What concerns you the most about your problem; what does it prevent you from doing?

18. What is your: Height _____ Weight _____ Age _____ Occupation: _____

PAGE 2 INTAKE FORM

19. How would you rate your overall Health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
20. What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None
21. Indicate if you have any immediate family members with any of the following:
☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Other: _____
☐ Heart Problems ☐ Cancer ☐ ALS
22. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		FOR FEMALES ONLY
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Live Births (indicate #) _____
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Miscarriages (indicate #) _____
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		

23. List all prescription medications you are currently taking: _____

24. List all of the over-the-counter medications you are currently taking: _____

25. List all surgical procedures you have had and dates: _____

26. Have you ever been hospitalized? ☐ NO ☐ YES if yes, list dates: _____

27. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day

24. What activities do you do outside of work? _____

26. Have you had significant past trauma? ☐ NO ☐ YES if yes, explain: _____

27. Anything else pertinent to your visit today? _____

Patient Signature: _____ Date: _____

CONSENT & AUTHORIZATION

____ (Initial) **Consent to Obtain Medical Records:**

I hereby authorize Complete Healthcare Medical Center, P.C. to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

____ (Initial) **Consent to Release Medical Information and/or Records:**

I hereby authorize Complete Healthcare Medical Center, P.C. to release my medical records to other physicians or medical facilities necessary in the course of my treatment. I now hold harmless other physicians or medical facilities from and all claims resulting from this release.

____ (Initial) **Pregnancy Disclaimer: (Females Only)**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Date of last menstrual period: _____

☐ Yes. I am definitely pregnant

☐ I request that x-ray films not be taken because _____

☐ There is a possibility that I may be pregnant at this time.

☐ No. I am definitely not pregnant at this time

____ (Initial) **Authorizations:**

I give permission to Complete Healthcare Medical Center, P.C. to use my address, email address, and phone numbers to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, information about treatment alternatives, newsletters, discounts/specials, testimonials, or other health related information.

____ (Initial) **Nutrition Disclaimer**

I understand that Complete Healthcare Medical Center P.C. nutritional program or supplement suggestions made to me by the wellness coach are for educational purposes only. Supplements are not intended to diagnose, treat, cure, or prevent any disease, and have not been evaluated by the FDA.

____ (Initial) **Consent for Treatment:**

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician. In the case that the patient is a minor, the consent below is being given on his/her behalf.

____ (Initial) **Acknowledgement of Privacy Rights:**

I acknowledge that Complete Healthcare Medical Center, P.C. has made available to me the Notice of Privacy Practices and Individual Rights. I acknowledge that I have read the Notice of Privacy Practices and Individual Rights, and I am giving my consent, and acknowledging that I have been informed of my rights to privacy.

____ (Initial) **Acknowledgement of Payment**

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize Complete Healthcare Medical Center, P.C., to release any information you deem 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 by Complete Healthcare Medical Center, P.C., and I hereby release you of any consequence thereof. Furthermore, I understand that Complete Healthcare Medical Center, P.C., will assist me in making my collection. I authorize direct payment to Complete Healthcare Medical Center, P.C., of any sum, I now or hereafter owe you, by my attorney out of proceeds of any settlement of my case and/or any insurance company obligated to reimburse me for the charges for the services or otherwise obligated to make payment on me or you based in whole in part upon the charges made for your services. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Name (Print Name)

Patient/Signature

Date

Witness Name (Print Name)

Witness/Signature

Date

consentandauthorization 2012



3460 Summit Ridge Parkway, Suite 103 Duluth, GA 30096

770/813-0087, FAX: 770/8/13-9006

Website: CHCduluthga.com

To: All Patients

From: Insurance Department

RE: Insurance Payments Directly to Patients

Should your insurance company send direct reimbursements to you for services rendered at Complete Healthcare Medical Center, P.C., please do the following:

- 1) Endorse all checks
- 2) Either mail or bring to the clinic within 10 days of receipt of the check
- 3) Include the explanation of benefits

Should you have any questions please do not hesitate to contact Harriet Selman, in the insurance department of Complete Healthcare Medical Center, P.C.

Thank You

Patient Name: _____

Patient Signature: _____

Date: _____

Witness: _____

WELLNESS SURVEY

PATIENT NAME _____ Date _____

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACITIVITY: ☐ Sitting ☐ Light ☐ Heavy

Do you have high stress in your life: ☐ Yes ☐ No Reason: _____

HABITS: ☐ Tobacco Use Packs/Day _____ ☐ Alcohol Use Drinks/Week _____ ☐ Caffeine Use Cups/Day _____

Please complete the following questionnaire. Describe each symptom based upon your experiences over the last 60 days.

Symptom Scoring System (please circle the appropriate number below):

0 = No Symptoms (zero points)

2 = Experience Moderate Symptoms (two points)

1 = Experience Mild Symptoms (one point)

3 = Severe Symptoms (three points)

Head/Ears

0 1 2 3 Migraines

0 1 2 3 Headaches

0 1 2 3 Earaches

0 1 2 3 Ear Infection

0 1 2 3 Ringing in Ears

Digestive

0 1 2 3 Stomach Pains/Cramping

0 1 2 3 Constipation/Diarrhea

0 1 2 3 Reflux/Heartburn

0 1 2 3 Bloating/Gas

0 1 2 3 Nausea/Vomiting

0 1 2 3 GI Upset from Specific Foods

Musculo-Skeletal

0 1 2 3 Joint Pain

0 1 2 3 Arthritis

0 1 2 3 Tendonitis

0 1 2 3 Muscle Aches

Genito-Urinary

0 1 2 3 Bladder Irritation/Pain

0 1 2 3 Frequent UTIs

0 1 2 3 Yeast Infections

Prior Heart Screening

0 1 2 3 Chest X-ray

0 1 2 3 ECG

0 1 2 3 Cardiac Biomarkers

0 1 2 3 Atherosclerosis

Respiratory/Sinus

0 1 2 3 Stuffy or Runny Nose

0 1 2 3 Chest Congestion

0 1 2 3 Chronic Cough

0 1 2 3 Wheezing

0 1 2 3 Frequent Sneezing

Skin Disorders

0 1 2 3 Eczema/Psoriasis

0 1 2 3 Dermatitis

0 1 2 3 Excessive Sweating

0 1 2 3 Rashes/Hives

0 1 2 3 Dry Skin

0 1 2 3 Acne

Eyes/Throat

0 1 2 3 Itchy/Dry Eyes

0 1 2 3 Watery Eyes

0 1 2 3 Sore Throat

0 1 2 3 Persistent Canker Sores

Cardio-Vascular

0 1 2 3 Irregular Heartbeat

0 1 2 3 Heart Palpitations

0 1 2 3 Chest Pains

0 1 2 3 Shortness of breath

0 1 2 3 Stroke

0 1 2 3 Murmur

Vascular

0 1 2 3 Varicose Veins

0 1 2 3 Swelling of hands/feet

0 1 2 3 Cold/Hot hands/feet

0 1 2 3 Blood clot in extremity

Energy

0 1 2 3 Fatigue

0 1 2 3 Hyperactivity

0 1 2 3 Lethargy

0 1 2 3 Restlessness

0 1 2 3 Difficulty Sleeping

Emotional/Mental

0 1 2 3 Depression

0 1 2 3 Anxiety

0 1 2 3 Mood Swings

0 1 2 3 Irritability

0 1 2 3 Poor Concentration

0 1 2 3 Poor Memory

Weight

0 1 2 3 Inability to Lose Weight

0 1 2 3 Food Cravings

0 1 2 3 Binge Eating

0 1 2 3 Water Retention

Other Symptoms

0 1 2 3 Thyroid Issues

0 1 2 3 High Blood Pressure

0 1 2 3 Blood Sugar Control

0 1 2 3 Libido Issues

Extremity

0 1 2 3 Numbness/tingling arms hands legs feet

0 1 2 3 Extremity pain arms hands legs feet

Please list any symptoms not mentioned above: _____

Comments: _____

ARE YOU AT RISK FOR PERIPHERAL ARTERIAL DISEASE? (PAD)

Your answer to these questions will help you know

DO YOU HAVE:

Cardiovascular (heart) problems such as high blood pressure,
Heart attack or stroke?

YES / NO

Diabetes?

YES / NO

A family history of diabetes or cardiovascular problems
(immediate family such as parent, brother or sister?)

YES / NO

Aching cramping or pain in your legs when you walk or exercise
but then the pain goes away when you rest?

YES / NO

Pain in your toes or feet at night?

YES / NO

Any ulcers or sores on your feet or legs that are slow in healing?

YES / NO

An inactive lifestyle?

YES / NO

Do you smoke?

YES / NO

Have you ever smoked?

YES / NO

**The higher your score the more important it is for you to see your doctor.
You and your doctor may wish to discuss the responses to this
questionnaire.**

Score: _____