Cumming Chiropractic Center, P.C.

What's New

Patient Update

1 ABOUT YOU

Today's Date:_____

Name:_____
Last First MI

Address:_____

_____
City State Zip

Home Phone: ( )_____

( )_____ ( ) _____
Cell phone Office phone

E-mail:_____

Which do you prefer text or email appointment reminder? Please circle one Text or email

Cell phone provider_____

Employer:_____

Occupation:_____How long?_____

Marital Status: M D W S

Spouse's Name_____

2 INSURANCE INFO

Do you have Health Insurance?

❑No ❑Yes *If NO, please continue to block 3.*

Co. Name_____

Insured's Name_____

Relation:_____Date of Birth_____

Insured's Employer:_____

initial I hereby authorize assignment of my insurance and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this time).

Please provide insurance card(s) with this form.

3 REASON FOR VISIT

Reason for today's visit: ❑New Injury ❑Old Injury ❑Other _____

Rate your pain: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ When did condition occur? _____(most recent)

Did your condition occur during: ❑Routine/Household activity ❑Sports/play ❑Auto accident ❑Other_____

Describe health concern_____

_____

4 HEALTH HISTORY

What medications are you taking? (please include over-the-counter drugs, vitamins)_____

_____

Have you ever had any falls, accidents or injuries: Give dates and explain_____

_____

Have you had any surgery's? ❑No ❑Yes Explain, give dates_____

_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided

Signature_____ Date____/____/____

HEALTH REVIEW

Name_____ Date of Birth_____ Today's Date_____

Please check all symptoms you have experienced.

CARDIOVASCULAR
- ☐ general swelling
- ☐ swelling in legs
- ☐ swelling in face / eyes
- ☐ chest pain
- ☐ heart "jumps"/ pounds
- ☐ rapid heart beat/ irreg
- ☐ hypertension
- ☐ heart attack
- ☐ harden of arteries
- ☐ pain over the heart
- ☐ blood vessel disease (phlebitis, etc.)
- ☐ any family member had stroke

VERTEBROBASILAR
- ☐ double vision / blurred
- ☐ loss of coordination
- ☐ irregular muscle movement
- ☐ ringing in ears
- ☐ high blood pressure
- ☐ areas of muscle weakness
- ☐ dizziness with nausea
- ☐ dizziness without nausea
- ☐ fainting spells
- ☐ loss of memory
- ☐ inability to form words
- ☐ had a stroke
- ☐ periods of blindness

WOMEN ONLY
- ☐ painful period
- ☐ spotting
- ☐ vaginal discharge
- ☐ premenstrual symptoms
- ☐ irregular periods
- ☐ birth control
- ☐ lumps in breast

pregnancies _____
deliveries _____
Are you pregnant?
☐ YES ☐ NO

MUSCULOSKELETAL
HEAD
- ☐ frequent headache
- ☐ severe headache
- ☐ head feels heavy
- ☐ vertigo
- ☐ light headedness
- ☐ loss of smell
- ☐ loss of taste
- ☐ loss of balance
- ☐ dizziness

10/12

NECK
- ☐ neck pain / stiffness
- ☐ neck pain w/ movement
- ☐ swelling in neck
- ☐ pinched nerve in neck
- ☐ neck feels out of place
- ☐ muscle spasms in neck
- ☐ grinding sounds in neck
- ☐ popping sounds in neck

SHOULDERS
- ☐ pain in shoulder R-L-Both
- ☐ pain across shoulders
- ☐ tension in shoulders
- ☐ muscle spasms in shoulders
- ☐ can't raise arm Rt / Lt
  - ☐ above shoulder level
  - ☐ over head

ARMS & HANDS
- ☐ pain in upper arm R-L-Both
- ☐ pain in forearm
- ☐ pain in hand R-L-Both
- ☐ pain in fingers R-L-Both
- ☐ sensation of pins & needles
  - ☐ arms
  - ☐ in fingers
- ☐ fingers go to sleep
- ☐ cold hands
- ☐ swollen joints in fingers
- ☐ sore joints in finger
- ☐ loss of grip strength R - L- Both

MIDBACK
- ☐ mid back pain
- ☐ sharp stabbing pain
- ☐ dull ache
- ☐ pain front to back
- ☐ pain kidney area
- ☐ muscle spasms in mid back area

LOWBACK
- ☐ low back pain
- ☐ back feels out of place
- ☐ muscle strains

HIPS, LEGS & FEET
- ☐ pain in buttocks
- ☐ pain down leg R-L-Both
- ☐ knee pain R-L-Both
- ☐ leg cramps R-L-Both
- ☐ pins &needles in legs
- ☐ numbness in legs /toes
- ☐ cold feet
- ☐ swollen ankles / feet

SKIN/NAILS/HAIR
- ☐ eczema
- ☐ itchy / dry skin
- ☐ dry scalp
- ☐ psoriasis
- ☐ yellow skin
- ☐ bruise easily
- ☐ pale skin

EYES
- ☐ blurring of vision
- ☐ double vision
- ☐ eyes fatigue easily
- ☐ excessive tearing
- ☐ lack of tearing
- ☐ light bothers eyes
- ☐ excessive itching
- ☐ pain in eyeball

EARS
- ☐ loss of hearing
- ☐ pain in ears
- ☐ ear infections
- ☐ discharge from ears
- ☐ vertigo
- ☐ ringing in ears

NOSE NASOPHARYNX SINUSES
- ☐ unusual nasal discharge
- ☐ nose bleeds
- ☐ pressure over eyes
- ☐ pressure under eyes
- ☐ obstruction of nose
- ☐ frequent colds
- ☐ sinusitis
- ☐ nasal allergies
- ☐ loss of sense of smell

MOUTH AND THROAT
- ☐ pain in mouth
- ☐ pain of throat
- ☐ bleeding gums
- ☐ cavities
- ☐ abscessed teeth
- ☐ difficulty swallowing
- ☐ changes in voice

VENERAL DISEASE
- ☐ AIDS
- ☐ syphilis
- ☐ gonorrhea
- ☐ other

RESPIRATORY
- ☐ shortness of breath
- ☐ can't breath while lying down
- ☐ can't sleep while lying down
- ☐ dry cough
- ☐ productive cough
- ☐ coughing up blood
- ☐ wheezing
- ☐ asthma / bronchitis

GASTROINTESTINAL
- ☐ poor appetite
- ☐ indigestion / heartburn
- ☐ can't eat some foods
- ☐ nausea & vomiting
- ☐ jaundice
- ☐ abdominal pain
- ☐ change in bowel habit
- ☐ diarrhea
- ☐ constipation
- ☐ hemorrhoids

GENITOURINARY
Urination is: ☐ frequent ☐ normal ☐ infrequent
Urine amount is: ☐ high ☐ normal ☐ low
- ☐ need to get up at night to urinate
- ☐ abnormal intense desire to urinate
- ☐ difficulty starting urination
- ☐ decreased output
- ☐ pain urinating
- ☐ dribbling
- ☐ blood in urine
- ☐ cloudy urine
- ☐ lack of bladder control
- ☐ prostate problems (male)

SOCIAL HISTORY
- ☐ smoking / tobacco use
- ☐ alcohol use

Diet is: ☐ balanced ☐ not balanced
Sleep is: ☐ sufficient ☐ insufficient
Exercise is: ☐ sufficient ☐ insufficient
My family stress is: ☐ severe ☐ moderate ☐ minimal
How do you like your work? ☐ very much ☐ ok ☐ hate it
My job stress is: ☐ severe ☐ moderate ☐ minimal

- ☐ nervousness
- ☐ fatigue
- ☐ depression
- ☐ generally feel run-down

Employment, Activities of Daily Living (ADL's) and Recreation Information

Patient Name: _____ Date: _____

Description of Work: _____

Condition's Effect On Job Performance:

☐ No Effect ☐ Mild Painful (Can do) ☐ Mod Painful (Limited) ☐ Severe (Unable to Perform)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Care- Infirm Family:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Carrying Groceries:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Change Pstn Sit to Stand:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Extended Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Feeding:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lift Children:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Pet Care:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Bathing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Dressing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Shaving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sexual Activities:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Static Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Static Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Yard Work:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

Recreational Activity: Effects of Current Condition on Performance

_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

(Examples: running, golfing, bowling, tennis, shopping, water sports, cycling, football, basketball, weight train, aerobics, biking, swimming, hunting, fishing, gardening, etc.)

Cumming Chiropractic Center

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Cumming Chiropractic Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

CUMMING CHIROPRACTIC CENTER

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Dr. Jason M. Gregory

www.drjasongregory.com

Phone: (770) 889-2208

Fax: (770) 889-0277

I give Cumming Chiropractic Center permission to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Signature: _____

Date: _____

I decline the right to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Signature: _____

Date: _____