Patient Name_____ Date_____

New Patient Intake Form

How did you hear about our office? _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Preferred Contact:: (Circle one) Cell Home Work **Email** _____

Cell Phone (____) ____-_____ **Home Phone** (____) _____-_____ **Work Phone** (____) _____-_____

Date of Birth _____/_____/_____ **Sex:** Male Female **Height** ____ **Weight** _____lbs

Social Security Number: _____-_____-_____ **Marital Status:** Single Married Other

Race & Ethnicity African American Asian American Indian Hispanic White Native Hawaiian **Decline**

Preferred Language: English Spanish Other_____

Are your symptoms a result of: Motor Vehicle Accident Work Related Accident Other_____

Employment Status: Employed Unemployed FT Student PT Student Other_____

Employer _____

Your Occupation _____

Spouse: First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Spouse Date of Birth _____/_____/_____

<u>Emergency Contact</u>

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____

Payment Method Please circle one: Self Pay Insurance

***If insurance who is insured**_____ **D O B** ___/___/____

Doctor's Signature _____

Patient Name_____ Date_____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other _____		

Allergies: (Check all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical _____	Sulfites	Wheat/Glutens	Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia

Other _____

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Occupational Activities: (Check one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

Doctor's Signature _____

Patient Name_____ Date_____

Review of Systems – (Check box if you have had trouble with any of the following Past or Present)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all **current medications** being taken _____

_____

Are You Pregnant? (Circle) **Yes No**

Blood Pressure Systolic____ **Diastolic**____ **Pulse**_____

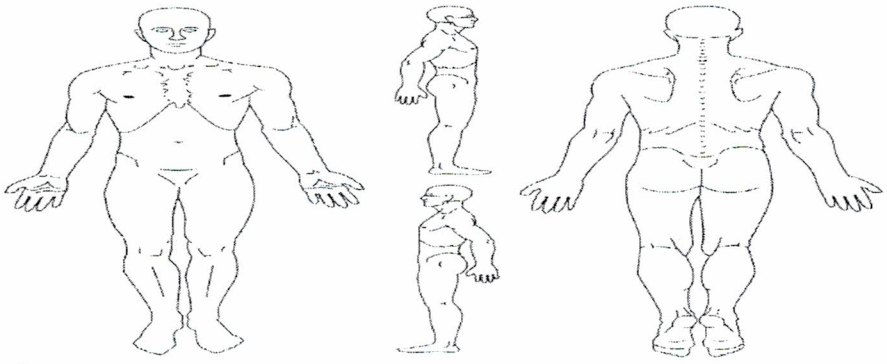
Doctor's Signature _____

Patient Name_____ Date_____

Major Complaint_____ **Secondary Complaints**_____

By Using the key below, <u>indicate on the body diagram</u> where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How are your symptoms changing? Getting better Not changing Getting worse

When did your symptoms begin? Date: Be Specific as possible _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Ache	Stiff	Shooting
Burning	Tingling/Numb	Throbbing	Other _____

What makes your symptoms better? Ice Heat Stretch OTC Medication Prescription Meds Other_____

What things make it worse? Sitting Bending Standing Lying/Sleep Walking Lifting Exercise Computer Work

Any previous treatment? Chiropractic Family MD Physical Therapy ER/Urgent Care Orthopedic Neuro

Previous Diagnostic Testing? None X-ray MRI CT Other_____

At its worst, what does it prevent you from doing? _____

At its worst, how does it make you feel? _____

What has you worried about this problem? _____

What <u>one thing or activity</u> would you do if you could get rid of this problem?_____

WELLNESS SURVEY

PATIENT NAME _____ **DATE**_____

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy **HABITS:**

WORK ACTIVITY: ☐ Sitting ☐ Standing ☐ Light ☐ Heavy ☐ Tobacco Use: Packs/Day___ ☐ Alcohol Use: Drinks/Week ____

Do you have high stress in your life? ☐ Yes ☐ No ☐ Caffeine Use: Cups/Day ___

Reason_____

Each symptom based upon your experiences over last 60 days. (Please circle the appropriate number below):

0 = No Symptoms **1 = Mild Symptoms** **2 = Moderate Symptoms** **3 = Severe Symptoms**

Head

0 1 2 3 Migraines
0 1 2 3 Headaches

Ears

0 1 2 3 Earaches
0 1 2 3 Ear Infection
0 1 2 3 Ringing in Ears
0 1 2 3 Itching
0 1 2 3 Fullness/popping
0 1 2 3 Hearing problems

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
0 1 2 3 Loss of Height

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 Abdominal Fat

Respiratory/Sinus

0 1 2 3 Stuffy or Runny Nose
0 1 2 3 Chest/Sinus Congestion
0 1 2 3 Chronic Cough
0 1 2 3 Wheezing/Shortness of Breath
0 1 2 3 Itching/Sneezing
0 1 2 3 Drainage. Color:
0 1 2 3 Frequent sinus infections
0 1 2 3 Change in sense of smell

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
0 1 2 3 Redness/Swelling
0 1 2 3 Post nasal drip
0 1 2 3 Throat clearing

Cardio-Vascular

0 1 2 3 Irregular Heartbeat
0 1 2 3 Heart Palpitations
0 1 2 3 Chest Pains

Genito-Urinary

0 1 2 3 Bladder Irritation / Pain
0 1 2 3 Frequent UTIs
0 1 2 3 Yeast Infections
0 1 2 3 Increase Frequency Urination
0 1 2 3 Blood in Urine

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 Memory

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
0 1 2 3 Low strength / Endurance

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
0 1 2 3 Declined Intimacy

Please list any symptoms not mentioned above: _____

FOR OFFICE USE ONLY

☐ Musculo-Skeletal ☐ GI Profile ☐ Fatigue Panel ☐ Wellness Panel ☐ Weight Loss ☐ hCG
☐ Food Sensitivity ☐ Cyrex Array3 ☐ Thyroid Panel ☐ Allergy Testing Weight _____
☐ ASI ☐ Genetic Celiac Panel ☐ Hormone Panel **F M** ☐ Other _____ Body Fat % _____

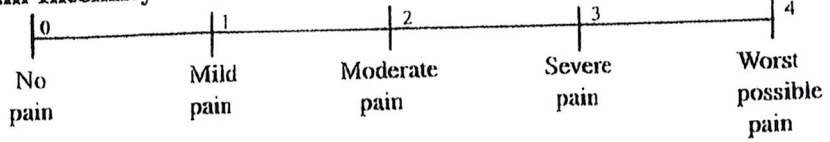
Comments:_____

Functional Rating Index

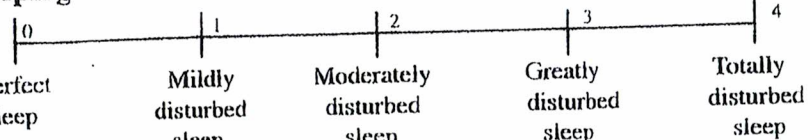
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

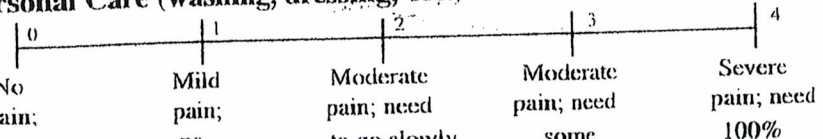
1. Pain Intensity



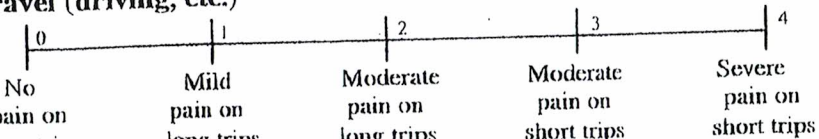
2. Sleeping



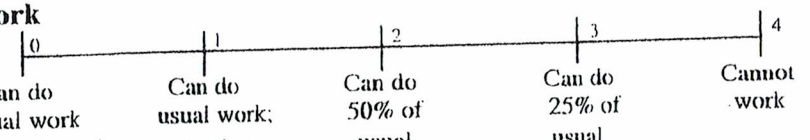
3. Personal Care (washing, dressing, etc.)



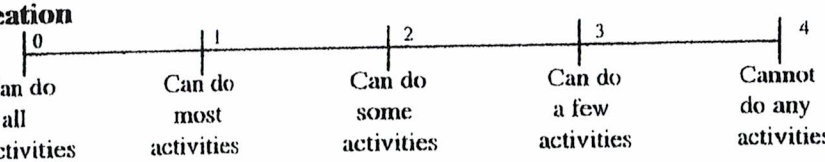
4. Travel (driving, etc.)



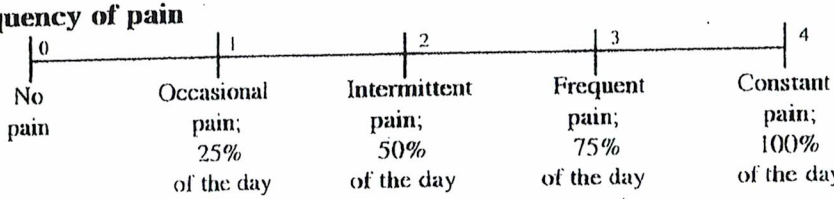
5. Work



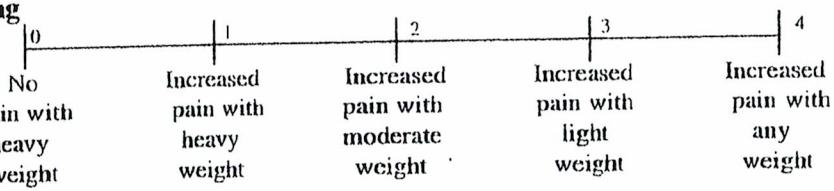
6. Recreation



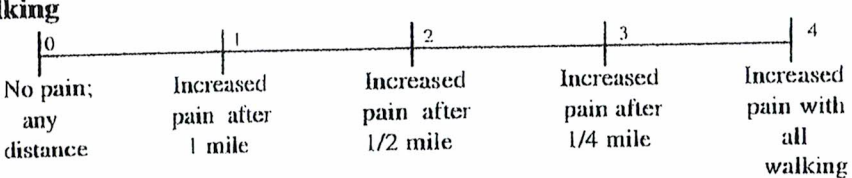
7. Frequency of pain



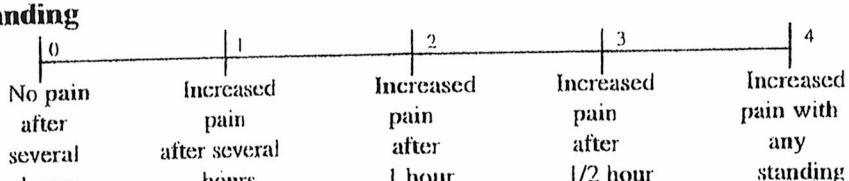
8. Lifting



9. Walking



10. Standing



Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____ _____

Signature **Date**

ASSIGNMENT, UCC LIEN, AND AUTHORIZATION FOR DIRECT PAYMENTS BY MY PAYERS TO NORTH GA DIAGNOSTIC & REHAB

PURPOSE AND CONSIDERATION; TERMS WHICH PAYERS MAY BE REQUIRING. The purpose of this Assignment & UCC Lien is to assist the Office in obtaining Proceeds from various Payers (including without limit my Attorney) for the payment of my Charges. In consideration for receiving / continuing health care at the Office based on terms which Payers may be requiring, as well as on terms set forth in various documents of the Office, I agree to the following and direct all Payers as follows:

DEFINITIONS. In this Assignment & UCC Lien, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to **North GA Diagnostic & Rehab** located at **5610 Bethelview Rd. #300 Cumming, GA. 30040**; "Assignment & UCC Lien Document," "Assignment & UCC Lien," "Assignment & Lien," and other like phrases shall refer to this document. "Payer" shall refer to without limit any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future; "Proceeds" shall include without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, the proceeds relating to "health-care-insurance receivables" and "payment intangibles" as such are defined by the applicable Uniform Commercial Code, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical expense or payments benefits ("Medpay"), personal injury protection ("PIP"), lost wages, lost services, property damage, errors & omissions, and malpractice; "Charges" shall include without limit the full fees for the Office's goods and services (including without limit treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions, and testimony), whether rendered before or after the date of this Assignment & UCC Lien, any Additional Costs incurred by the Office as defined herein, delinquency penalties and interest to the maximum extent permitted under law or at the annual rate of eighteen percent (18%), whichever is greater, and any other charges incurred by me at the Office; "Additional Costs" shall include without limit any costs incurred by the Office relating directly or indirectly to (i) the goods or services associated with my Charges, (ii) this Assignment & UCC Lien, (iii) the application or enforcement of any law relating to the issue of the Office's Charges, secured interests or its goods and services, (iv) any effort or action to collect my Charges either from me or from any Payer, or (v) any legal or medico-legal action, process, or claim of any nature against, or by, the Office or its employees for any reason relating to the foregoing items, (i)-(iv), of the previous clause ("Medico-Legal Process"). "Additional Costs shall further include without limit an hourly fee of $25.00 for our Office's administrative staff time, as well as an hourly fee of $500.00 for any lost-time at work by any treating or diagnosing health care provider employed by or contracted with our Office, relating to any of the foregoing items. "Medico-Legal Process" shall include without limit civil and administrative proceedings, mediation, arbitration, interpleader actions, cross-claims or counterclaims, requests for reconsideration, independent reviews, and internal appeals. Costs associated with such Medico-Legal Processes shall also include without limit any pre- and post-judgment costs, filing fees, service of process charges, and attorney's fees. In determining the Office's Charges, I hereby waive any defense or argument that such costs shall not apply or be awarded based on the claim that the Office's goods or services were somehow (i) not sufficiently necessary or effective, related to an accident, documented or otherwise warranted, or (ii) inappropriately directed, delivered, conducted or administered.

ASSIGNMENT AND UCC LIEN TERMS. (i) Assignment Terms: I hereby assign to the Office to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Office's name and as the Office otherwise sees fit. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. (ii) UCC Lien Terms: I further intend for this Assignment & UCC Lien to create a security interest under the applicable Uniform Commercial Code; accordingly, I hereby grant to the Office a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges ("UCC Lien"), the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred; I further authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as the Office sees fit in its sole discretion; I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. (iii) Other Assignment and UCC Lien Terms: Consistent with the foregoing terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & UCC Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which the Office may have and elect to exercise under said law.

Initials ____

SPECIFIC DIRECTION TO ANY ATTORNEY I RETAIN, SUCH AS IN ACCIDENT CASES. In the event that I retain one or more attorneys relating to my Claims to Proceeds, I hereby direct (and the Office hereby requests) each attorney to review the terms of this Assignment & UCC Lien, including without limit the fact that I may become responsible for various costs arising hereunder. Accordingly, I respectfully request that each attorney not unilaterally assume to arbitrate potential disputes relating to this Assignment & UCC Lien. I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute with the Office, attorney, or any other party for any reason, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the Office for any portion of the Charges. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Office to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

DISCLOSURE DIRECTIVES TO ALL PAYERS. I hereby direct each and every Payer to immediately release to the Office any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to the Office's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to the Office's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct the Office to release any information relating any services rendered to or for me by the Office to all Payers, including without limit a copy of my Charges and a copy of this Assignment & UCC Lien, unless otherwise agreed to in writing.

MISCELLANEOUS. Except as provided in this paragraph, this Assignment & UCC Lien shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & UCC Lien. I agree that each and every provision of this Assignment & UCC Lien is reasonably necessary. However, should any provision of this Assignment & UCC Lien be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & UCC Lien shall, nevertheless, remain in full force and effect. I agree to indemnify and hold the Office harmless for Charges, including without limit any Additional Costs as defined herein. This Assignment & UCC Lien shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment & UCC Lien, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & UCC Lien.

I have read, understood, and agree to the terms of this Assignment & UCC Lien.

Patient Name (print): _____

Patient Signature: _____ Date: ___/___/_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print):_____

Parent/Guardian Signature: _____ Date: ___/___/_____

HIPAA Acknowledgement and Consent

Name_____ Date_____ Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law. **Initial**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE.

I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing chiropractor Dr. Gregory King, D.C. or any other doctors employed by Backsmart Health LLC. I understand, and am informed that, while extremely rare, there are some risks as with any medical treatment including, but not limited to: fractures, disc injuries, cardiovascular accidents, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment. **Initial**_____

Patient signature_____ **Date**_____

Parent/Legal guardian name(please print)_____

Guardian Signature_____ **Date**_____