Kellie C. Baxter, DC • *Specializing in Chiropractic and Injury*
6875 Hickory Road Suite 110 • Woodstock, GA 30188
t. 770.345.1111 • f. 770.345.1788 • ReviveWoodstock.com

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New Patient Intake Forms

Personal Information

Name (First & Last): _____ Date: _____/_____/_____
Date of Birth: _____/_____/_____ Sex (Circle one): Male / Female
Marital Status: [ ]Single [ ]Married [ ]Widowed [ ]Divorced [ ]Separated Spouse's Name:_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone:_____ Cell Phone: _____ Email:_____
Our office has the capability to send you text & email reminders. Which do you prefer? (Circle one: Text Email Both
How did you hear about us? Family/Friend/Co-Worker?: _____
Facebook Instagram Google Drive by Insurance Other: _____

Emergency Contact

First Name: _____ Last Name: _____
Phone Number: _____ Relationship: [ ]Spouse [ ]Relative [ ]Friend [ ]Other_____
Your Primary Care Physician: _____ Physician Phone Number: _____

Employment Information

Business Name: _____ Occupation: _____
Address: _____ City:_____ State:_____ Zip:_____

Insurance Information

Insurance Carrier:_____ Policy Number:_____ Insured's DOB:_____
Who carries this policy? [ ]Self [ ]Spouse [ ]Parent Insured's Name:_____

Previous care for this condition

Have you seen another professional for this condition *other* than a chiropractor? [ ]Yes [ ]No
If yes, who? (Name): _____ Practice: _____
Type of treatment: _____
Were you satisfied with the results of your treatment? [ ]Yes [ ]No

Previous chiropractic care

Have you seen a chiropractor before? [ ]Yes [ ]No If yes, please fill out the information below:
Doctor's Name: _____ Location: _____ Date of last visit: _____
Were you satisfied with your care? [ ]Yes [ ]No _____
For how long did you treat? _____ Approximately how many visits? _____

Social History

Job Stress: [ ]None [ ]Moderate [ ]Severe Your Job Duty: [ ]Sedentary (<5 lbs) [ ]Light (5-20 lbs) [ ]Heavy (>50 lbs)
Job Description: _____ Family Stress: [ ]None [ ]Moderate [ ]Severe
Average hours of sleep per night?_____ Overall Sense of Wellbeing: [ ]Pleased [ ]Satisfactory [ ]Displeased
Dietary Habits: [ ]Skip Breakfast [ ] Two meals a day [ ]Three meals a day [ ]Snack between meals
Coffee Intake: [ ]Daily [ ]Weekly How Many Cups?_____ Water Intake: [ ]Daily [ ]Weekly How Many Glasses?_____
Do you take pain relievers? [ ]Daily [ ]Weekly How much?_____ Do you drink soft drinks? [ ]Yes [ ]No
Would you consider your current lifestyle [ ]Healthy [ ]Unhealthy [ ]Could improve healthy habits
Do you have any pins, plates or screws? [ ]No [ ]Yes / Location:_____

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Name: _____ Date_____

What is your chief complaint? (Why are you here? Please mention only one area of complaint)

_____

_____

When did this condition begin? ____/____/____ What tends to lessen the problem?_____

Is the condition:

Auto Related Job Related Home Injury Slip or Fall Lifting Slept Wrong Gradual Repetitive Sudden

Other Please explain: _____

_____

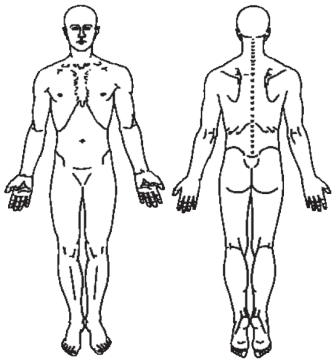
Has it ever occurred before? [ ]No [ ]Yes,When? _____ The pain is worse in the [ ]Morning [ ]Evening

Frequency you experience this symptom? [ ]Constant [ ]Frequent [ ]Intermittent [ ]Occasional

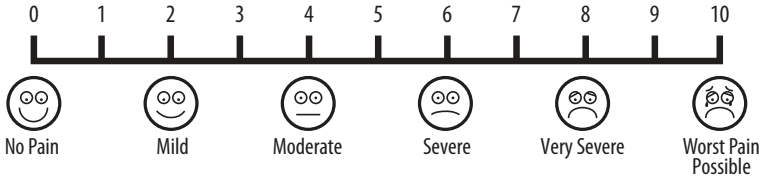
Describe the pain (How does it feel?) [ ]Numb [ ]Tingling [ ]Stiff [ ]Aching [ ]Stabbing [ ]Throbbing [ ]Dull [ ]Burning

Does the pain shoot or radiate to another area of your body? [ ]No [ ]Yes If yes, location:_____

Please circle all areas where you are experiencing symptoms on the figures to the right.



Please rate the intensity of your pain using the scale below.
Circle the number that best describes your pain.



Please list any additional complaints (in order of importance)

1._____When did it start?_____

2._____When did it start?_____

3._____When did it start?_____

Effects of current condition on daily activities or performance (Check most accurate for each activity)

Reaching overhead	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Bending / Turning	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Carrying / Lifting	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Sitting to standing	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Climbing Stairs	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Driving	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Computer Use	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Household Chores	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Lifting	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Concentration	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Bathing / Dressing	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Sleep	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Sitting	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Standing	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Walking	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Lying Down	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Yard Work	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Exercise	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain
Job Performance	[ ] No Pain	[ ] Mild Pain	[ ] Moderate Pain	[ ] Severe Pain

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Name: _____ Date_____

Current medications (please list any/all medications you are *currently* taking)

Medication	Dosage	For what condition?	Length of time using

Current supplements (please list any/all non-prescription items you are *currently* taking)

Supplement	Dosage	For what condition?	Length of time using

Family History

Some health issues are hereditary. Are there any hereditary health issues that anyone in your immediate family has that we should know about? _____
_____

Personal History

Illnesses:_____
_____

Allergies: [ ]No [ ]Yes If yes, please check all that apply: [ ]Seasonal [ ]Food_____ [ ]Medication_____
_____

Please check any of the following treatments you are currently having:
[ ]Massage Therapy [ ]Physical therapy [ ] Acupuncture [ ]Chemotherapy [ ]Dialysis [ ]Blood transfusions [ ]Herbs
[ ]Hormone replacement therapy [ ]Birth control [ ]Infusions [ ]IV Vitamin therapy [ ]Essential oils [ ]Homeopathy
Please list any prior injuries / concussions / fractures / accidents / hospitalizations: _____
_____
_____

Surgery History

[ ]I have not had any surgical procedures

[ ]Angioplasty	[ ]Tonsillectomy	[ ]Hysterectomy	[ ]Pacemaker insertion	[ ]Gallbladder
[ ]Appendectomy	[ ]Gallbladder	[ ]Joint Reconstruction	[ ]Rotator Cuff	[ ]D&C
[ ]Caesarian Section	[ ]Dental Surgery	[ ]Joint Replacement	[ ]Spinal Fusion	[ ]Cosmetic
[ ]Cardiac Cath.	[ ]Knee repair	[ ]Carpal tunnel	[ ]Laminectomy	[ ]Discectomy
[ ]Coronary Bypass	[ ]Mastectomy	[ ]Hernia	[ ]Other_____	

Acknowledgements /Agreement

Initials_____*FEMALES ONLY* I realize that x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge that I am not pregnant. Date of last menstrual period (_____/_____/_____)
Initials_____I grant permission to be called to confirm or reschedule an appointment and be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Initials_____To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresnted the presence, severity or cause of my health concern.

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Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure offYour Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation for the federal privacy standards.

Revocation offConsent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster, and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used within the office for purposes of my care, to those individuals designated by the doctor.

Patient or Guardian Signature X_____ Date: _____

Informed Consent For Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. There are some risks to treatment, including, but not limited to, muscle spasms, aggravating and /or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dizziness, headaches, discolorations, burns with modalities, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels best at the time, based upon the facts then known, and is in my best interests.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have had the opportunity to discuss with the doctor of chiropractic named below and / or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep my appointments as recommended to me by treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my examination from any other doctor. I will notify the facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ (print) have read, or had read to me, the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient or Guardian Signature: X_____ Date: _____

Financial Responsibility

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. *Also, any cost that is required for collection procedures will be added to my balance and will also become my responsibility. Failure to make payment on your account will result in your dismissal from the practice. Please note that we have a $35 returned check fee on all checks returned to us from our bank for non-sufficient funds which will be charged to your patient account and you will be responsible to pay.* All co-payments, co-insurance amounts, deductibles, and / or other patient due balances must be paid in full at the time of your visit. Insurance is an agreement between me and my carrier and I am ultimately responsible for the payment of covered and non covered services. We are participating with Medicare. We will bill Medicare for you. Please note federal law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance we will bill it after Medicare pays. Medicare at this time does not cover exams or x-rays if the billing doctor is a Doctor of Chiropractic. Medicare also does not cover wellness care / preventative / maintenance care, progress exams, therapies, massage therapy, or supplements. You will be responsible for these charges at the time of service. We accept cash, checks, Visa, Mastercard, American Express, Discover, Apple Pay and Care Credit.

Patient or Guardian Signature: X_____ Date: _____