Rasmussen Chiropractic Center for Wellness

200 East Lanier Avenue Fayetteville Georgia 30214

Confidential Patient Information (some required by Government)

Full Name____**Nickname**___________**Home Phone**____________________
First MI Last

Street Address____**City/St**______________________________**Zip**___________
Gender[ ]Male [ ]Female **Preferred Language**[ ]English [ ]Spanish [ ]Other **DOB**____/____/____ **Marital** M / S / D / W / SEP
Race[ ]White [ ]Am Indian or Alaska Indian [ ]Asian [ ]Black or African Am [ ]Native Hawaiian or Other [ ]*I decline to answer*
Ethnicity[ ]Hispanic or Latino [ ]NOT Hispanic [ ]*I decline to answer* **Preferred Contact**[ ]Phone [ ]Email [ ]Text [ ]Fax [ ]Mail

Cell Phone______________________**Email**____**Fax**_____________________

If Applicable: **Spouse's Full Name**____ **DOB**____/____/____

Do you have a **Family Doctor**? [ ]Yes [ ]No **Name of Doctor**____

Street Address____**City/St**______________________________**Zip**___________

Date of Last Visit____/____/____ Reason____ Date of Last Exam____/____/____

Have you been to a **Chiropractor** before?[ ]Yes [ ]No **Name of Doctor**____

Have you had any **Surgeries** in the last 5 years? [ ]Yes [ ]No If YES, last dates____/____/____ ____/____/____ ____/____/____

Types of Surgery____

How were you **referred** to our office? [ ]Doctor [ ]Family [ ]Friend [ ]Co-worker [ ]Other **Name**______________________________

Employment Status [ ]Retired [ ]Student[ ] FT/PT Employer____

Employer Address_____________________________________**City/St**______________________________**Zip**___________

Work Phone________________________**Occupation**__________________________**Job Duties**_________________________

Do You Plan to Submit an Insurance Claim [ ]Yes [ ]No

If so, please let the receptionist copy your primary and secondary insurance card and photo ID

Notice: Government Law requires ALL patients produce a Photo ID card

Primary Insurance Company____

Insured's Name____ **DOB**____/____/____

Secondary Insurance Company____

FINANCIAL ARRANGEMENTS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Rasmussen Chiropractic Center for Wellness will prepare any necessary reports and forms to assist me in making a collection from the insurance company and that any amount authorized to be paid directly to Rasmussen Chiropractic Center for Wellness will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that **I'm personally responsible for payment.** I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable upon receipt.
Method of payment for today's charges[ ]CASH [ ]CHECK [ ]CREDIT CARD VISA / MASTERCARD (circle one)

PAYMENT REQUIRED AT THE TIME OF VISIT UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE

CONSENT FOR TREATMENT OF PATIENT

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of chiropractic health care and give the authority for these procedures to be performed. It is understood and agreed that x-ray negatives taken at this office will remain property of this office, being on file where they may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical conditions receiving diagnosis and treatment outside of this office. We are pleased that you have chosen our office for chiropractic and alternative care. The care that we offer in our office is unique and designed to evaluate your condition in a very specific and individualized way. You should discuss your treatment options and request an informed consent form from your Doctor. I consent to treatment with my signature below

Patient's Consent Signature____ **Date**______________

CONTINUED ON NEXT PAGE (Signature is required again)

CONFIDENTIAL PATIENT HISTORY

Current Complaints "CC" [ ]Headache [ ]Neck Pain [ ]Upper Back [ ]Mid-back Pain [ ]Lower Back

Other health concerns, please describe here____

Is this a condition related to employment? [ ]Y [ ]N Is it related to an Auto Accident? [ ]Y [ ]N [ ]N/A

Date Problem Began____/____/____ How Problem began______________________________________

Current Complaints (Overall, how do you feel today?) Circle the number that applies No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable
How often are you Symptoms present? (Intermittent) [ ]0-25% [ ]26-50% [ ]51-75% [ ]76-100% (Constant)
In the past week, how much has your pain interfered with your daily activities? (e.g., work, social activities, household chores, etc.?)
No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities
Have you had recent X-RAYS, MRI, CT SCAN for your problem [ ]Y [ ]N When/What______________________________
PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU [ ]NONE APPLY

[ ] AIDS	[ ] *Numbness in Groin/Buttocks	[ ] *Cancer/Tumor(explain)________________
[ ] Loss of Memory	[ ] *Recent Fever	[ ] *Urinary Problems/Kidney Trouble
[ ] Sleeping Problems	[ ] *Diabetes	[ ] *Pain unrelieved by position or rest
[ ] Multiple Sclerosis	[ ] *High Blood Pressure	[ ] *Pain at night
[ ] Nervousness	[ ] *Taking Birth Control Pills	[ ] *Osteoporosis
[ ] Fatigue	[ ] *Stroke (date) ____/____/____	[ ] *Epilepsy/Seizures
[ ] Depression	[ ] *Visual Disturbances	[ ] *Abnormal Weight [ ]Gain [ ]Loss
[ ] Allergies	[ ] *Corticosteroid use (cortisone, prednisone)	[ ] *Marked Morning Pain/Stiffness
[ ] Anxiety/Panic Attacks	[ ] *Dizziness/Fainting	[ ] Heart or Valve Problems
[ ] Asthma	[ ] Diverticulitis	[ ] Thyroid Trouble
[ ] Arthritis	[ ] Cirrhosis/Hepatitis	[ ] Pacemaker

Conditions/Symptoms other than above____

FEMALE ONLY[ ]Painful Menstruation [ ]Vaginal Discharge [ ]Irregular Cycle [ ]Menopause [ ]PMS [ ]Breast Problem
Are you pregnant? [ ]N [ ]Not Sure [ ]Y # wks____ Date of Last Menstrual Cycle____/____/____
MALE ONLY[ ]Prostate Problems [ ]Urethral Discharge [ ]Difficulty Starting Stream/ [ ]Stopping Stream [ ]ED

How would you rate your general state of health? 0 to 10 with 10 being the best ________________
PAST HISTORY "PH" Have you ever had same or similar problems? [ ]N [ ]Y Date____/____/____
*List any Medications or pills you are currently taking (you may include drugs that you took before or provide on **separate sheet**)

NAME	DOSAGE (mg)	HOW OFTEN (ex. Once a wk)	NAME	DOSAGE (mg)	HOW OFTEN (ex. Once a wk)

Allergic to What Medications?____

Reactions[ ]Anaphylaxis [ ] Difficulty Breathing [ ] Nausea [ ] Rash [ ] Swelling [ ] Hives [ ] Angioedema [ ] Vomiting [ ] Myalgia [ ] Unspecified

List any Accidents or Injuries (i.e. Auto, Fell Down Steps, Broken Bones or Loss of Consciousness)

DATE	DESCRIPTION	DATE	DESCRIPTION

FAMILY HISTORY "FH" [ ]AIDS [ ]Allergies [ ]Anemia [ ]Arthritis [ ]Asthma [ ]Cancer [ ]Bone Fracture [ ]Heart Problems/Stroke
[ ]Diabetes [ ]HIV/ARC [ ]High Blood Pressure [ ]Kidney Trouble [ ]Spinal Disc Disease [ ]Low Blood Pressure [ ]Mental/Emotional
[ ]Rheumatic Fever [ ]STD's [ ]Sinus Trouble [ ]Epilepsy [ ]Thyroid Trouble [ ]TB [ ]Ulcer [ ]Polio/______________________
SOCIAL HISTORY "SH" Do you smoke? [ ] Y Packs per wk?____ [ ]Sometimes [ ]N [ ]Former Smoker [ ]Never Smoked
Alcohol? [ ]N [ ]Y Drinks/week?______ Caffeine? [ ]N [ ]Y Drinks/day?______
Do you exercise regularly? [ ]N [ ]Y Hours/week?________ (circle one) Light/Moderate/Strenuous
Do you take nutritional supplements [ ]N [ ]Y Which Ones?______________________________________
GOALS What are your goals upon entering this office? (Check as many as apply)
[ ]To Get Out of Pain [ ]To Improve Overall Function [ ]To Maintain Health [ ]To Learn How to Get Healthier
[ ]To Discover How to Manage This Chronic Condition [ ]To Rehabilitate an Injury [ ]To Prevent Degeneration (aging)
[ ]I would like to live healthier and learn about **BIO-SEPTOLOGY** – our unique *Life Style System* to enhance your genetic potential
ALL THIS INFORMATION IS KEPT PRIVATE/Please ask to see our Privacy Policy
I hereby authorize the release of my information you deem appropriate concerning my physical condition and my examination to any Insurance Company, Attorney or Adjuster in order to process my claim for reimbursement of charges incurred by me as a result of profession services rendered by you, and I hereby release you of any consequences thereof. I certify that the above information is complete and accurate. If the health plan information is not accurate, I understand that I am liable for all charges for services rendered.

Patient's Consent Signature____ **Date**______________

***Learn more about us at* www.rasmussenchiropractic.com**