Rasmussen Chiropractic Center for Wellness

200 East Lanier Avenue Fayetteville Georgia 30214

Welcome Back (it's been a while since your last visit)

Full Name_____**Nickname**_____**Home Phone**_____
First MI Last
Street Address_____**City/St**_____**Zip**_____
Gender[ ]Male [ ]Female **DOB**____/____/____ **Marital** M / S / D / W / SEP (Government wants this stuff!)
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_____
Employment Status [ ]Retired [ ]Student[ ] FT/PT Employer_____
Employer Address_____**City/St**_____**Zip**_____
Work Phone_____**Occupation**_____**Job Duties**_____

HISTORY: SINCE YOUR LAST VISIT TO OUR OFFICE, HAVE YOU….?

	YES	NO	IF YES, DESCRIBE BRIEFLY/When or Give Name
Changed your Insurance Company?	[ ]	[ ]	_____
Been Involved in Auto Accident?	[ ]	[ ]	_____
Had any personal injury?	[ ]	[ ]	_____
Had any serious illness?	[ ]	[ ]	_____
Been knocked unconscious?	[ ]	[ ]	_____
Been hospitalized, other than surgery?	[ ]	[ ]	_____
Have you seen any other doctors for this complaint?	[ ]	[ ]	_____

*List any **Medications or Pills** you are currently taking (you may include drugs that you took before or provide on separate sheet)

NAME	DOSAGE	HOW OFTEN ie (once daily)	NAME	DOSAGE	HOW OFTEN ie (once daily)
_____			_____		
_____			_____		
_____			_____		

Allergies to Medicine: _____
Reaction: [ ]Anaphylaxis [ ]Difficulty Breathing [ ]Nausea [ ]Rash [ ]Swelling [ ]Hives [ ]Angioderma [ ]Vomiting [ ]Myalgia [ ]Unspecified
Social History: 'SH' Do you smoke? [ ] No [ ]Yes Packs per day__+_ [ ]Sometimes [ ]Former Smoker [ ]Never Smoked
Alcohol? [ ] No [ ]Yes Drinks per week? ____Caffeine? [ ] No [ ]Yes Drinks per day?____
Do you exercise regularly? [ ] No [ ]Yes Hours per week?____ (circle one) Light / Moderate / Strenuous
Do you take nutritional supplements? [ ] No [ ]Yes Which ones?_____

Please describe your present **Symptoms or Complaints**_____
Date Problem Began: _____ How Problem Began: _____
Current Complaint (how you feel today) Circle Number that Applies **NO PAIN – 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 – Unbearable**
How often are your symptoms present? (intermittent) [ ] 0-25% [ ] 26%-50% [ ] 51-75% [ ] 76-100% (constant)

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**_____