COMPLETE HEALTHCARE MEDICAL CENTER, P.C. 3460 Summit Ridge Pkwy #103 Duluth, Ga 30096 Telephone:770-813-0087

PATIENT INFORMATION

Date:_____

_____
Last Name First Name Middle Name

_____
Address

_____
City State Zip

Email Address:_____

Cell (_____)_____ Home (_____)_____

Work (_____)_____ SS#_____

Date of Birth____/____/_____ Age_____ Gender: M F

Height_____ Weight_____ Married Widowed Single

Who is responsible for account?_____

In case of emergency please contact:

Name:_____ Phone (_____)_____

INSURANCE INFORMATION

Primary Insurance Company_____

Subscriber's Name_____

Relationship to Patient_____

Subscriber's Employer _____

Member #_____Group #_____

Subscriber's DOB _____/_____/_____ SS#_____

Secondary Insurance Company_____

Subscriber's Name_____

Relationship to Patient_____

Subscriber's Employer_____

Member #_____Group #_____

Subscriber's DOB _____/_____/_____ SS#_____

INSURANCE PAYMENTS SENT DIRECTLY TO PATIENTS

Should your insurance company send direct reimbursements to you for services rendered at Complete Healthcare Medical Center, P.C., please do the following:

1. Endorse all checks
2. Either mail or bring to the clinic within 10 days of receipt of check
3. Include the Explanation of Benefits

I fully understand that if my insurance company sends me a check, I will submit it to Complete Healthcare Medical Center, P.C. within 10 days of receipt of payment. If I do not submit payment in full then I full understanding that I will be sent to collections. Patient Initial_____

How did you hear about our office:

____ **I am a returning old patient** _____**At my work** (Company Name):_____

_____Savvy Shopper ___MTM _____Post Card ____Big Deals ___Internet ___Gift Certificate ___Walk-In

____CHC Employee ___Phone Marketing ___Living Social Doctor:_____

Who may we thank: Patient Referral:_____ Attorney:_____

PROMOTION ACKNOWLEDGEMENT (if applicable)

Acknowledgement of FREE SERVICES I, _____,hereby certify that I have received a consultation and examination at no charge. I understand that any charges for additional services are my financial responsibility.

_____Signature _____Date

Acknowledgement of Promotion Cost Promotion Code:_____ Patient Initial_____

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Telephone: 770-813-0087 Fax: 770-813-9006 website: CHCduluthga.com

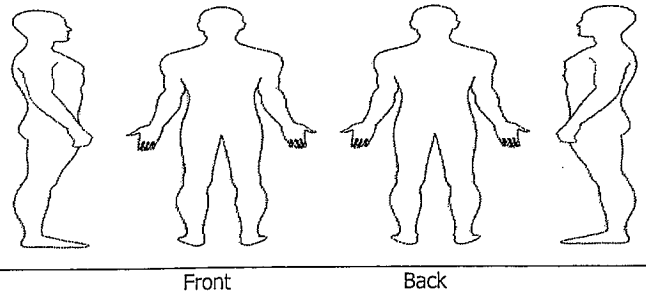
PATIENT INTAKE FORM

Patient Name:_____

1. Is today's problem caused by: ❑ Auto Accident ❑ Workman's Compensation ❑ None
2. What is the reason for today's visit:_____

_____

3. Indicate on the drawings below where you have pain/symptoms:



Front Back

Please list your complaints in order from worst (1) to least (10).

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

4. How often do you experience your symptoms:

❑ Constantly (76-100% of the time) ❑ Occasionally (26-50% of the time) ❑ N/A
❑ Frequently (51-75% of the time) ❑ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

❑ Sharp ❑ Numb
❑ Dull ❑ Tingly
❑ Diffuse ❑ Sharp with motion
❑ Achy ❑ Shooting with motion
❑ Burning ❑ Stabbing with motion
❑ Shooting ❑ Electric like with motion
❑ Stiff ❑ Other:_____

6. How are your symptoms changing with time?

❑ Getting Worse ❑ Staying the Same ❑ Getting Better ❑ N/A

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle) ❑ N/A

8. How much has the problem interfered with your work?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely ❑ N/A

9. How much has the problem interfered with your social activities?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely ❑ N/A

10. Who else have you seen for your problem(s)?

❑ Chiropractor ❑ Neurologist ❑ Primary Care Physician
❑ ER Physician ❑ Orthopedist ❑ Other _____
❑ Massage Therapist ❑ Physical Therapist ❑ No One

11. Have you had any x-rays taken of affected are(s)? ❑ NO ❑ YES if yes, list dates:_____
12. Have you had a MRI in the affected area(s)? ❑ NO ❑ YES if yes, list dates:_____
13. How long have you had this problem?_____
14. How do you think your problem began? _____
15. Do you consider this problem to be severe?

❑ Yes ❑ Yes, at times ❑ No

16. What aggravates your problem?_____
17. What concerns you the most about your problem; what does it prevent you from doing?

_____

18. What is your: Height_____ Weight_____ Age_____ Occupation:_____

19. How would you rate your overall Health? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

20. What type of exercise do you do? ❑ Strenuous ❑ Moderate ❑ Light ❑ None

21. Indicate if you have any immediate family members with any of the following:

❑ Rheumatoid Arthritis ❑ Diabetes ❑ Lupus ❑ Other:_____

❑ Heart Problems ❑ Cancer ❑ ALS

22. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
❑	❑ Headaches	❑	❑ High Blood Pressure	❑	❑ Diabetes
❑	❑ Neck Pain	❑	❑ Heart Attack	❑	❑ Excessive Thirst
❑	❑ Upper Back Pain	❑	❑ Chest Pain	❑	❑ Frequent Urination
❑	❑ Mid Back Pain	❑	❑ Stroke	❑	❑ Smoking/Tobacco Use
❑	❑ Low Back Pain	❑	❑ Angina	❑	❑ Drug/Alcohol Dependance
❑	❑ Shoulder Pain	❑	❑ Kidney Stones	❑	❑ Allergies
❑	❑ Elbow/Upper Arm Pain	❑	❑ Kidney Disorders	❑	❑ Depression
❑	❑ Wrist Pain	❑	❑ Bladder Infection	❑	❑ Systemic Lupus
❑	❑ Hand Pain	❑	❑ Painful Urination	❑	❑ Epilepsy
❑	❑ Hip Pain	❑	❑ Loss of Bladder Control	❑	❑ Dermatitis/Eczema/Rash
❑	❑ Upper Leg Pain	❑	❑ Prostate Problems	❑	❑ HIV/AIDS
❑	❑ Knee Pain	❑	❑ Abnormal Weight Gain/Loss		
❑	❑ Ankle/Foot Pain	❑	❑ Loss of Appetite		FOR FEMALES ONLY
❑	❑ Jaw Pain	❑	❑ Abdominal Pain	❑	❑ Birth Control Pills
❑	❑ Joint Pain	❑	❑ Ulcer	❑	❑ Hormonal Replacement
❑	❑ Arthritis	❑	❑ Hepatitis	❑	❑ Pregnancy
❑	❑ Rheumatoid Arthritis	❑	❑ Liver/Gall Bladder Disorder	❑	❑ Live Births (indicate #)_____
❑	❑ Cancer	❑	❑ General Fatigue	❑	❑ Miscarriages (indicate #)_____
❑	❑ Tumor	❑	❑ Muscular Incoordination	❑	❑ Other _____
❑	❑ Asthma	❑	❑ Visual Disturbances	❑	❑ Other _____
❑	❑ Chronic Sinusitis	❑	❑ Dizziness		

23. List all prescription medications you are currently taking: _____

_____

24. List all of the over-the-counter medications you are currently taking: _____

_____

25. List all surgical procedures you have had and dates: _____

_____

26. Have you ever been hospitalized? ❑ NO ❑ YES if yes, list dates:_____

27. What activities do you do at work?

❑ Sit:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ Stand:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ Computer work:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ On the phone:	❑ Most of the day	❑ Half the day	❑ A little of the day

24. What activities do you do outside of work? _____

_____

26. Have you had significant past trauma? ❑ NO ❑ YES if yes, explain:_____

_____

27. Anything else pertinent to your visit today? _____

_____

_____

Patient Signature:_____ Date: _____

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WELLNESS SURVEY

PATIENT NAME_____Date_____

EXERCISE: ❑ None ❑ Moderate ❑ Daily ❑ Heavy **WORK ACITIVITY:** ❑ Sitting ❑ Light ❑ Heavy

Do you have high stress in your life: ❑ Yes ❑ No Reason:_____

HABITS: ❑Tobacco Use Packs/Day_____ ❑ Alcohol Use Drinks/Week_____ ❑ Caffeine Use Cups/Day_____

Please complete the following questionnaire. Describe each symptom based upon your experiences over the last 60 days.

Symptom Scoring System (please circle the appropriate number below):

0 = No Symptoms (zero points)
1 = Experience Mild Symptoms (one point)
2 = Experience Moderate Symptoms (two points)
3 = Severe Symptoms (three points)

Head/Ears

0 1 2 3 Migraines
0 1 2 3 Headaches
0 1 2 3 Earaches
0 1 2 3 Ear Infection
0 1 2 3 Ringing in Ears

Respiratory/Sinus

0 1 2 3 Stuffy or Runny Nose
0 1 2 3 Chest Congestion
0 1 2 3 Chronic Cough
0 1 2 3 Wheezing
0 1 2 3 Frequent Sneezing

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

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

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

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 Concentration
0 1 2 3 Poor Memory

Musculo-Skeletal

0 1 2 3 Joint Pain
0 1 2 3 Arthritits
0 1 2 3 Tendonitits
0 1 2 3 Muscle Aches

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

Weight

0 1 2 3 Inability to Lose Weight
0 1 2 3 Food Carvings
0 1 2 3 Binge Eating
0 1 2 3 Water Retention

Genito-Urinary

0 1 2 3 Bladder Irritation/Pain
0 1 2 3 Frequent UTIs
0 1 2 3 Yeast Infections

Cardio-Vascular

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

Other Sym ptoms

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

Please list any symptoms not mentioned above:_____

FOR OFFICE USE ONLY

❑ Musculo-Skeletal ❑ HCG ❑ ALCAT ❑ Other_____
❑ Trigger Point Steriod ❑ B12 ❑ Male Hormone Panel ❑ Other_____
❑ Trigger Point Serapin ❑ Lipovite B1-B12, L-Carn ❑ Female Hormone Panel ❑ Other_____

Comments:_____

CONSENT & AUTHORIZATION

_____ (Intial) **Consent to Obtain Medical Records:**
I hereby authorize Complete Healthcare Medical Center, P.C. to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

_____ (Intial) **Consent to Release Medical Information and/or Records:**
I hereby authorize Complete Healthcare Medical Center, P.C. to release my medical records to other physicians or medical facilities necessary in the course of my treatment. I now hold harmless other physicians or medical facilities from and all claims resulting from this release.

_____ (Intial) **Pregnancy Disclaimer: (Females Only)**
Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Date of last menstrual period:_____

- ☐ Yes. I am definitely pregnant
- ☐ I request that x-ray films not be taken because _____
- ☐ There is a possibility that I may be pregnant at this time.
- ☐ No. I am definitely not pregnant at this time

_____ (Intial) **Authorizations:**
I give permission to Complete Healthcare Medical Center, P.C. to use my address, email address, and phone numbers to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, information about treatment alternatives, newsletters, discounts/specials, testimonials, or other health related information.

_____ (Intial) **Nutrition Disclaimer**
I understand that Complete Healthcare Medical Center P.C. nutritional program or supplement suggestions made to me by the wellness coach are for educational purposes only. Supplements are not intended to diagnose, treat, cure, or prevent any disease, and have not been evaluated by the FDA.

_____ (Intial) **Consent for Treatment:**
A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician. In the case that the patient is a minor, the consent below is being given on his/her behalf.

_____ (Intial) **Acknowledgement of Privacy Rights:**
I acknowledge that Complete Healthcare Medical Center, P.C. has made available to me the Notice of Privacy Practices and Individual Rights. I acknowledge that I have read the Notice of Privacy Practices and Individual Rights, and I am giving my consent, and acknowledging that I have been informed of my rights to privacy.

_____ (Intial) **Acknowledgement of Payment**
I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize Complete Healthcare Medical Center, P.C., to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Complete Healthcare Medical Center, P.C., and I hereby release you of any consequence thereof. Furthermore, I understand that Complete Healthcare Medical Center, P.C.., will assist me in making my collection. I authorize direct payment to Complete Healthcare Medical Center, P.C., of any sum, I now or hereafter owe you, by my attorney out of proceeds of any settlement of my case and/or any insurance company obligated to reimburse me for the charges for the services or otherwise obligated to make payment o me or you based in whole in part upon the charges made for your services. I clearly understand and agree that all services rendered to me are charged directly to ma and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Name (Print Name)	Patient/Signature	Date
Witness Name (Print Name)	Witness/Signature	Date