Georgia Sports Chiropractic

Please Print Clearly

Name:_____
Last First MI

"Preferred Name" to be called by:_____ Email**:**_____

Address:_____
Street City State Zip

DOB:_____ Age:_____ Sex:_____ SSN#: __ __ __ - __ __ - __ __ __ __

☑Please check a box for the preferred # to call to confirm or reschedule appointments:

☐ Home#_____ ☐ Cell#_____ ☐ Work#_____

Occupation: _____ Employed By:_____

Emergency Contact:_____ Relationship:_____ Phone#:_____

Chief Complaint:

1. Please describe how the injury/pain started.

_____
_____

2. Please describe current pain and any other symptoms.

_____
_____

3. Any previous treatment by another physician for this problem?

_____
_____

4. Any previous accidents or other athletic injuries?

_____
_____

Request for Payment of Benefits to Provider of Care

I herby authorize the _____ Insurance Company/ Insurance Administrator to pay directly to: Georgia Sports Chiropractic the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges.

_____
Patient Signature Date

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How did you hear about us?:_____ ***Name of Referral*:**_____

Have you seen a Chiropractor before?____ Was it this year?_____ How many times?_____

Name of Previous Chiropractor: _____

Medicines/Allergies:

What medications are you currently taking? (Drug name, dose, and times per day) Write N/A if you are not taking any at this time:

_____

_____

_____

Social History

Smoker: Yes ___ No___ If yes, how many packs per week: _____

Alcohol: Yes ___ No___ If yes, how many drinks per week: _____

Past Medical History

1. **Medical Problems (Current or past) Not including your current injury:**

_____

_____

_____

_____

2. **Prior surgeries:**

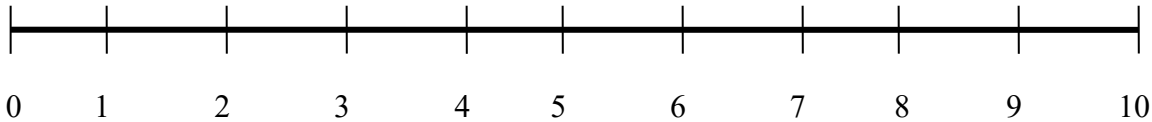
_____

_____

_____

Numerical Rating Scale:

Please place a mark on the line that corresponds to your *current* pain level:



0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN EVER

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Athletic Injury Profile

What types of sports are you involved in?

1. Major Sports:_____

2. How Many Years? _____

(Only for **Student Athletes**) School?: _____
Running Club or Track Club?: _____

3. Cross Training:_____

4. Are you part of a gym? _____ Cross Fit?_____

5. Average weekly distance or duration?:
Running:_____ Cycling:_____ Swimming:_____

6. Current weekly distance or duration?:
Running:_____ Cycling:_____ Swimming:_____

7. Shoes? Brand:_____ Style :_____ Type:_____
(Ex. Nike) (Ex. Pegasus) (Neutral or stability)

8. Do you wear orthotics? Yes_____ No_____
If so, who prescribed and made the orthotics?_____

9. Are you training for specific goals in mind? (E.g. 10k, Marathon, Ironman, etc.)

_____
_____
_____

10. Do you stretch? Yes_____ No____ If yes, how and when?

_____
_____
_____

11. Do you ice or use any system of home rehab/strengthening?

_____
_____
_____

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Informed Consent for Treatment

I, _____, do hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

Although spinal manipulation /adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associates with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. Also, I am aware the possibility of bruising and soreness with soft tissue therapy. Bruising and soreness are temporary.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to the aforementioned. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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

Patient Signature:_____ Date:_____

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Consent for Use or Disclosure of Health Information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we will always respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form (Article 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us anytime for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding to us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____
Printed Name

_____ _____
Signature Date

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