5456 BETHELVIEW RD STE 103B CUMMING, GA 30040 | P (770) 406-8208| F (770) 406-8204 www.arisefamilychiropractic.com

ARISE
FAMILY CHIROPRACTIC

HRN: _____

ADULT INTAKE PAPERWORK

HELLO AND WELCOME TO ARISE!

Who may we thank for referring you / how did you hear about us? _____

Have you received chiropractic care in the past? ❑ No ❑ Yes (from whom?) _____

Please fill out the following information completely and to the best of your ability.
Remember to initial the bottom of each page.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Gender: ❑ Male ❑ Female

Email: _____ Marital Status: ❑ S ❑ M ❑ D ❑ W

Street Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____

Occupation/Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship to You: _____

Cell Phone: _____ Hobbies: _____

Name(s) & Age(s) of Children: _____

PERSONAL HEALTH HISTORY

Height: __ft ___in Weight: ____lbs

What is your typical daily work activity?

❑ Sitting ❑ Standing ❑ Working at a Computer
❑ Manual Labor ❑ Light Lifting ❑ Heavy Lifting
❑ Driving ❑ Other: _____

Indicate if you have experienced the following:

❑ N/A ❑ Been unconscious due to an illness or injury
❑ Serious illnesses, operation, or health emergency
❑ Motor vehicle accident ❑ Fractured a bone
Explain (include year(s)): _____

Do you have any genetic disorders or disabilities? ❑ No ❑ Yes *If yes, explain*: _____

_____

SOCIAL HISTORY

Do you smoke?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Are you exposed to secondhand smoke?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Do you drink alcohol?	❑ Never	❑ In the Past	❑ ___drinks /week	❑ Daily
Do you use recreational drugs?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
How often do you exercise?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily

PAST HISTORY

Has your symptom/pain/reason for seeking chiropractic care happened BEFORE? ❑ No ❑ Yes

What treatment did you seek? ❑ N/A _____ How were your results? ❑ Good ❑ Poor

Help us identify past conditions or procedures that could be ***related to your main issue***:

❑ N/A ❑ Past surgeries ❑ Childhood diseases ❑ Past injuries *Explain:* _____

Have you experienced or been diagnosed with any of the following?

❑ N/A ❑ Pain that wakes you up at night ❑ Night Sweats ❑ Stroke ❑ Heart Attack ❑ Diabetes

INITIALS _____

CHIEF COMPLAINT / HISTORY OF PRESENTING ILLNESS

Name: _____ Date: _____

What is the MAIN symptom/pain/reason you are seeking chiropractic care?

PROBLEM/CONCERN #1: _____

- Rate your CURRENT pain/discomfort: ____/10 WHEN did the problem begin? _____
- Did you do something/did something happen that caused/aggravated the problem?
  ❑ No ❑ Yes *If yes, explain:* _____
- Does the problem RADIATE outward? ❑ No ❑ Yes *If yes, where?* _____
- HOW OFTEN do you experience the problem?
  ❑ always ❑ often ❑ occasionally ❑ rarely ❑ monthly ❑ weekly ❑ daily (❑ AM / ❑ PM)
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- What RELIEVES the problem? _____ What makes the problem WORSE? _____

Are there any SECONDARY health concerns you wish to bring to our attention?

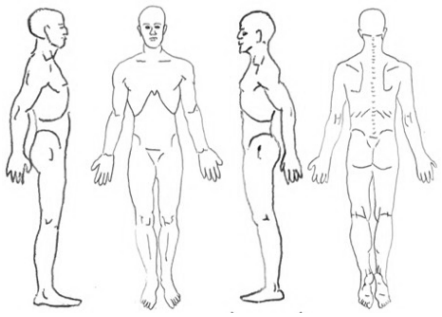
PROBLEM/CONCERN #2: ❑ N/A _____

- Rate your CURRENT pain/discomfort: ____/10 WHEN did the problem begin? _____
- Did you do something/did something happen that caused/aggravated the problem?
  ❑ No ❑ Yes *If yes, explain:* _____
- Does the problem RADIATE outward? ❑ No ❑ Yes *If yes, where?* _____
- HOW OFTEN do you experience the problem?
  ❑ Always ❑ Often ❑ Occasionally ❑ Rarely ❑ Monthly ❑ Weekly ❑ Daily (❑ AM / ❑ PM)
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- What RELIEVES the problem? _____ What makes the problem WORSE? _____

Directions: On the diagrams to the RIGHT, CIRCLE the area(s) that to your pain/symptom(s):

How would you describe the problem(s)?

❑ Dull ache ❑ Deep/boring ❑ Numb
❑ Pounding ❑ Stiff/tight ❑ Sharp/stabbing
❑ Radiating ❑ Tingling ❑ Burning
❑ Other: _____



CHIROPRACTIC & HEALTH LIFESTYLE GOALS

What are your health and lifestyle goals you hope to achieve while under chiropractic care?
PLEASE CHECK ALL THAT APPLY:

❑ Decrease the *severity* & *intensity* of my pain/problem(s)
❑ Decrease the *frequency* of my pain/problem(s) (how often I experience the pain/problem(s))
❑ With my corrective chiropractic care, I hope to be able to… _____

ACTIVITIES OF DAILY LIVING

DIRECTIONS: Assess your ability / lack of ability to complete the following activities.

Activity	CAN COMPLETE *Without* Pain or Difficulty	CAN COMPLETE *With Minimal* Pain or Difficulty	CAN COMPLETE *With Significant* Pain or Difficulty	CANNOT COMPLETE Due to Pain	N/A
Bathe/Shower	❑	❑	❑	❑	❑
Shaving	❑	❑	❑	❑	❑
Sexual Activity	❑	❑	❑	❑	❑
Climbing Stairs	❑	❑	❑	❑	❑
Getting Dressed	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑
Daily Physical Activities	❑	❑	❑	❑	❑
Standing	❑	❑	❑	❑	❑
Walking	❑	❑	❑	❑	❑
Sitting	❑	❑	❑	❑	❑
Yard Work	❑	❑	❑	❑	❑
Lift Children	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Move from Seated to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Carry Bag/Purse/Groceries	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑

List Prescription & Non-Prescription drugs you take: _____

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Check the box that applies to conditions that you have experienced CURRENTLY, in the PAST, or NEVER

CONDITION	CURRENT	PAST	NEVER		
Acid Reflux/Heartburn/GERD	❑	❑	❑		
ADHD/ADD	❑	❑	❑		
Allergies	❑	❑	❑		
Anxiety	❑	❑	❑		
Arthritis/Joint Pain	❑	❑	❑		
Asthma/Difficulty Breathing	❑	❑	❑		
Autism Spectrum	❑	❑	❑		
Cancer	❑	❑	❑		
Carpal Tunnel Syndrome	❑	❑	❑		
Chest Pain	❑	❑	❑		
Depression	❑	❑	❑		
Diabetes	❑	❑	❑		
Difficulty Sleeping	❑	❑	❑		
Disc Problems	❑	❑	❑		
Dizziness/Vertigo	❑	❑	❑		
Ear Problems	❑	❑	❑		
Epilepsy	❑	❑	❑		
Fibromyalgia	❑	❑	❑		
Headaches/Migraines	❑	❑	❑		
Hemorrhoids	❑	❑	❑		
High/Low Blood Pressure	❑	❑	❑		
Infertility	❑	❑	❑		
Irritable Bowel Syndrome	❑	❑	❑		
Menstrual Dysfunction	❑	❑	❑		
Mood Changes/Irritability	❑	❑	❑		
Numbness/Tingling	❑	❑	❑		
Scoliosis	❑	❑	❑		
Sinus Problems	❑	❑	❑		
Swelling of Legs/Feet	❑	❑	❑		
TMJ/Jaw Pain	❑	❑	❑		
Tremors	❑	❑	❑		
* Organic / System Problems	❑	❑	❑		

* Select ALL that apply: ❑ Digestive ❑ Gallbladder ❑ Heart ❑ Liver ❑ Stomach ❑ Pancreas ❑ Reproductive ❑ Lung/Respiratory ❑ Urinary ❑ Kidney ❑ Prostate ❑ Vision ❑ Thyroid ❑ Skin ❑ Sexual ❑ Other(s) _____ *Explain*: _____
_____

Name: _____ Date: _____

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

ARISE FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign and return with the rest of your paperwork. Should you want to keep a copy of this form for your records, you may ask our front desk receptionist to create a copy.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency, we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance (72 hours).
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Dr. Caitlyn Cortner at (770)406-8208. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

Signature: _____ Date: _____

ARISE FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE (CONTINUED)

I have received a copy of Arise Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me by the front desk receptionist at my request. At this time, I do not have any questions regarding my rights or any of the information I have received.

Name: _____ Date: _____

Signature: _____ Date of Birth: _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Arise Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Signature: _____ Date: _____

AUTHORIZATION FOR X-RAYS

X-rays are utilized in the office to help locate and analyze **vertebral subluxations**. The doctor(s) of Arise Family Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Signature: _____ Date: _____

(**Women Only)** Please check the box that applies to you - To the best of my knowledge:

❑ I **AM** NOT pregnant at this time

❑ I **AM**/believe **I MAY BE** pregnant, therefore I **DO** <u>NOT</u> authorize Arise Family Chiropractic to X-ray me at this time.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Arise Family Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Arise Family Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Arise Family Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Signature: _____ Date: _____