

Wakeman Chiropractic and Healing Center

2803 Shallowford Road Atlanta, Georgia 30341. 404-364-0900 admin@wakemanchiropractic.com

Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist.

Please Print

Name _____ Today's Date _____

Address _____ Home Phone (____) _____

City _____ State _____ Zip _____ Cellular Number (____) _____

Age _____ Birth of Date _____ SS # _____

Email: _____ Payment type: ☐ Cash ☐ Check ☐ C.C.

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Male ☐ Female

Referred By: _____

Major Complaints _____

Is this due to an accident? ☐ Yes ☐ No If yes Date of Accident _____

Type of Accident: ☐ Auto Accident ☐ Workmen's Comp

Do you have health insurance? ☐ Yes ☐ No

Insurance Company _____ Policy ID Number _____

Insurance Address _____ Phone (____) _____

Emergency contact Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____ Phone (____) _____

Notice: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance. On all insurance the deductible must be met in the beginning unless prior arrangements are made. I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that **I am personally responsible for payment of any and all services covered or non covered.** I also understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me, will be immediately due and payable.

Patient's Signature _____ Date _____

Spouse or Guardian's _____ Date _____

Patient's Name: _____

Name of spouse or Parent _____ Birth Date _____

Parent/Spouse's Employer _____ Years on the job _____

Employer's Address _____ City _____ State _____ Zip _____

Work Phone (____) _____ SS # _____

List all of your current health problems:

List any other doctors seen and treatment received:

List all dates and surgeries you have had:

List any medications you are now taking:

Have you ever been in an automobile accident? _____ When? _____

Have you ever been in a work related accident or any other injury for which you received treatment?
When? _____

Please check the conditions you have or have had:

_____ AIDS
_____ ANEMIA
_____ ARTHRITIS
_____ CANCER
_____ POLIO
_____ TUBERCLOSIS
_____ ALLERGIES If yes, please list: _____

_____ EPILEPSY
_____ HYPOGLYCEMIA
_____ MULTIPLE SCLEROSIS
_____ PARKINSON'S DISEASE
_____ RHEUMATIC FEVER

Patient's Name: _____

Please check all **PRESENT** symptoms:

MUSCULOSKELETAL SYSTEM

HEAD

- ___ Frequent headache
- ___ Head feels heavy
- ___ Light-headedness
- ___ Loss of smell
- ___ Loss of taste
- ___ Loss of balance
- ___ Dizziness

SHOULDERS

- ___ Pain in shoulders
(right, left)
- ___ Pain across shoulders
- ___ Muscle spasms
- ___ Can't raise arm
- ___ Above shoulder level
- ___ Over head

HIPS, LEGS & FEET

- ___ Pain in buttock
- ___ Pain down leg R/L
- ___ Knee pain R/L
- ___ Leg cramps
- ___ Pins & needles
- ___ Numbness in toes
- ___ Cold feet
- ___ Swollen ankles

NECK

- ___ Pain in neck
- ___ Neck pain with movement
- ___ Swelling in neck
- ___ Stiff neck
- ___ Pinched nerve in neck
- ___ Muscle spasms in neck
- ___ Grinding sounds in neck
- ___ Popping sounds in neck

ARMS & HANDS

- ___ Pain in upper arm
- ___ Pain in forearm
- ___ Pain in hands
- ___ Pain in fingers
- ___ Sensation of pins & needles
___ in arms
___ in fingers
- ___ Fingers go to sleep
- ___ Hands cold
- ___ Swollen joints in fingers
- ___ Sore joints in fingers

MID BACK PAIN

- ___ Mid back pain
- ___ Pain between shoulder blades
- ___ Muscle spasm in mid back

LOW BACK PAIN

- ___ Low back pain
- ___ Muscle spasm in low back

Difficulty in: ___ Standing ___ Sitting ___ Bending ___ Walking ___ Lifting
Pain Radiating: ___ Right arm ___ Left arm ___ Right leg ___ left leg ___ Neck ___ Base of skull

OTHER (Symptoms not described above): _____

Patient's Name _____

SOCIAL HISTORY

My **diet** is: ___ Balanced ___ Not balanced ___

My **rest** is: ___ Sufficient ___ Not sufficient

My **recreation** is: ___ Sufficient ___ Not sufficient

How do you like **your job**: ___ Very much ___ It's ok ___ I hate it

My **family stress** is: ___ normal ___ low ___ Moderate ___ Severe

My **job stress** is: ___ Minimal ___ Moderate ___ Severe

___ **Smoking**; # / day = ___

___ **Other tobacco** use

___ **Alcohol** use

___ **Coffee or tea**

PLEASE SHOW US WHERE IT HURTS

On the line below, indicate where your level of pain is **NOW**:

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

0= no pain 5=moderate pain 10=worst imaginable pain

Please mark the area(s) showing the type of discomfort you have using the provided markings. Place the appropriate markings on the region of discomfort.

Numbness
~~~~~

**Pins & Needles**  
000000

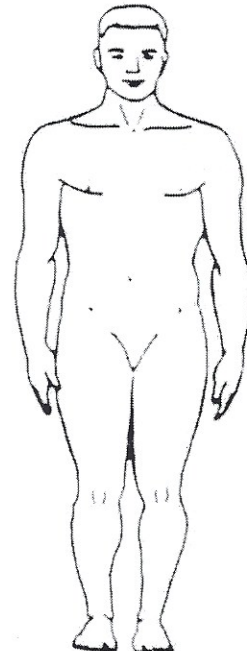
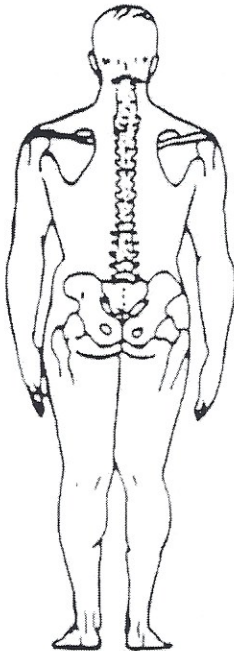
**Burning**  
^ ^ ^ ^

**Aching**  
x x x x

**Stabbing**  
\* \* \* \*

**Dull Pain**  
# # # #

**Tingling**  
+ + + +



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## INFORMED CONSENT FOR DIAGNOSTIC EVALUATION AND RELATED TREATMENT

I, \_\_\_\_\_, understand that in order to receive evaluation and treatment by the healthcare providers at **Wakeman Chiropractic & Healing Center, P.C.**, various diagnostic testing such as x-rays, nerve conduction studies, diagnostic ultrasound, MRI, or any other tests (as may be needed for the evaluation of my condition) could be indicated. I further understand and agree that my care at the above referenced office may involve services rendered by doctors of chiropractic (DC), physical therapist (PT), or other ancillary staff.

I authorize the healthcare providers at **Wakeman Chiropractic & Healing Center, P.C.** to perform such diagnostic examinations necessary to help determine the course of care and also to administer whatever treatment is deemed necessary in order to treat my present problems (or illnesses) as they see fit. I understand that as in all forms of healthcare delivery systems, there may be certain risks involved in administering and or receiving chiropractic or medical treatments or physiotherapeutic modalities. It is my understanding that such risk factor(s) may be explained to me upon my request by the treating doctor(s) or healthcare providers.

DATE: \_\_\_\_\_ PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ WITNESS: \_\_\_\_\_

### FEMALES ONLY

By my signature on this form I, \_\_\_\_\_, do hereby state that to the best of my knowledge, I am not pregnant, neither suspected nor confirmed at this particular time.

FIRST DAY OF LAST MENSTRUAL PERIOD: \_\_\_\_\_

DATE: \_\_\_\_\_ PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ WITNESS: \_\_\_\_\_

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## Authorization to Release Medical Information

I, authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Print name: \_\_\_\_\_ Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_ Witness signature: \_\_\_\_\_

## Request for Payment of Benefits to Provider of Care

I hereby authorize the \_\_\_\_\_ Insurance Company/ Insurance Administrator to pay by check, and for it to be mailed directly to: \_\_\_\_\_ 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. I agree that this office be given power of attorney to endorse/ sign my name on any and all drafts for payment of my bill.

I, also certify and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM DIRECTLY RESPONSIBLE FOR PAYMENT.**

Print name: \_\_\_\_\_ Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_ Witness signature: \_\_\_\_\_

## Attorney Representation and Protection of Balance

I, the undersigned patient am directing my Attorney, \_\_\_\_\_, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Print name: \_\_\_\_\_ Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_ Witness signature: \_\_\_\_\_

## Consent for Treatment of a Minor

I hereby authorize \_\_\_\_\_, D.C. and whomever he/she may designate as his/her associate(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship to child) \_\_\_\_\_ (child's name) \_\_\_\_\_.

Print name: \_\_\_\_\_ Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_ Witness signature: \_\_\_\_\_

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## INFORMED CONSENT TO JOINT MANIPULATION/MOBILIZATION AND CARE

I \_\_\_\_\_ hereby request and consent to the performance of joint manipulation/mobilization and other procedures including various modes of physiotherapy and diagnostic x-rays on \_\_\_\_\_ (self/ minor child) by any of the above named doctors and/or any other doctor(s) appointed by him/her, including those working at the above clinic, to administer what ever treatment deemed necessary to treat for any problem(s) or illness..

I have had the opportunity to discuss with the doctor(s) or clinic personnel the nature and purpose of joint manipulation/mobilization and other procedures. I understand that the results are not guaranteed.

I understand and am informed that as in the practice of chiropractic and physiotherapy there are some risks to the treatments including but not limited to reaction to therapeutic oils, fractures, burns, stroke, nerve damage, strains, and death. I do not expect the doctor(s) to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor(s) to exercise judgment during the course of the procedures which the doctor(s) feel at the time, based on fact then known, is in my best interest.

I have read the above consent and had an opportunity to ask questions about this consent. By signing below I agree to the above named procedures and will not hold the doctor(s), the clinic, and/or its employees responsible. This consent will cover the entire course of my treatment for my present condition(s).

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

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## New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my health care, Wakeman Chiropractic & Healing Center, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Wakeman Chiropractic & Healing Center, P.C. not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Wakeman Chiropractic & Healing Center, P.C. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Wakeman Chiropractic & Healing Center, P.C. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_

\_\_\_\_\_

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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## CANCELLATION/ NO SHOW POLICY FOR SCHEDULED CHIROPRACTIC APPOINTMENTS

IF AN APPOINTMENT IS NOT CANCELLED AT LEAST  
**24 HOURS** IN ADVANCE YOU WILL BE CHARGED  
A FIFTY DOLLAR **(\$50) FEE**;  
THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.  
(\*Same day cancellation by way of email, text or our notification system applies.)

We understand that there are times you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature Patient/ Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Account# (Office Use only)