



NAME: _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Social Security # _____

Occupation: _____

Employer: _____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):_____

_____**3. Past Health History:****A. Please indicate if you have a history of any of the following:**

- ☐ Anticoagulant use ☐ Heart problems/high blood pressure/chest pain ☐ Bleeding problems
☐ Lung problems/shortness of breath ☐ Cancer ☐ Diabetes ☐ Psychiatric disorders
☐ Bipolar disorder ☐ Major depression ☐ Schizophrenia ☐ Stroke/TIA's ☐ Other _____
☐ None of the above

B. Previous Injury or Trauma:

Have you ever broken any bones? Which?

C. Allergies: _____

D. Medications:

Medication and Reason for taking

E. Surgeries:

Date

Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery

Outcome

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- ☐ Cancer ☐ Strokes/TIA's ☐ Headaches ☐ Cardiac disease ☐ Neurological diseases
☐ Adopted/Unknown ☐ Cardiac disease below age 40 ☐ Psychiatric disease ☐ Diabetes
☐ Other _____ ☐ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death

Age at death

Social and Occupational History:

A. Job description:

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B. Work schedule:

--

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐ Other _____ ☐ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease ☐ Heart attacks/MIs ☐ Heart disease/problems ☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat ☐ Other _____
☐ None of the above

Have you had any of the following **neurological (nerve-related)** issues?

☐ Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of seizures ☐ One-sided decreased feeling in the face or body ☐ Headaches ☐ Memory loss ☐ Tremors ☐ Vertigo ☐ Loss of sense of smell
☐ Strokes/TIAs ☐ Other _____ ☐ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes
☐ Other _____ ☐ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

☐ Renal calculi/stones ☐ Hematuria (blood in the urine) ☐ Incontinence (can't control) ☐ Bladder Infections
☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other _____ ☐ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

☐ Nausea ☐ Difficulty swallowing ☐ Ulcerative disease ☐ Frequent abdominal pain ☐ Hiatal hernia ☐ Constipation
☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools
☐ Vomiting blood ☐ Bowel incontinence ☐ Gastroesophageal reflux/heartburn ☐ Other _____ ☐ None of the above

Have you had any of the following **hematological (blood-related)** issues?

☐ Anemia ☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ☐ HIV positive
☐ Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia
☐ Hyper coagulation or deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy ☐ Regular aspirin use
☐ Other _____ ☐ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

☐ Significant burns ☐ Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other _____ ☐ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

☐ Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken bones ☐ Spinal fracture ☐ Spinal surgery ☐ Joint surgery
☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal implants ☐ Other _____ ☐ None of the above

Have you had any of the following **psychological** issues?

☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations ☐ Bipolar disorder ☐ Homicidal ideations ☐ Schizophrenia
☐ Psychiatric hospitalizations ☐ Other _____ ☐ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to The Paulk Clinic for services performed.

Patient or Guardian Signature _____

Date _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1

C. On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:

1 2 3 4 5 6 7 8 9 10

D. What percentage of the time you are awake do you experience the above symptom at the above intensity:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one) suddenly gradually
 - How did the symptom begin? _____
 - What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
 - What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- E. Describe how the symptom feels (circle all that apply):
- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- F. Does the symptom move to another part of your body (circle one): yes no
- If yes, where does the symptom move? _____
- G. Is the symptom worse at certain times of the day or night? (circle one)
- Morning Afternoon Evening Night Unaffected by time of day

Symptom 2

H. On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:

1 2 3 4 5 6 7 8 9 10

I. What percentage of the time you are awake do you experience the above symptom at the above intensity:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one) suddenly gradually
 - How did the symptom begin? _____
 - What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
 - What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- J. Describe how the symptom feels (circle all that apply):
- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- K. Does the symptom move to another part of your body (circle one): yes no
- If yes, where does the symptom move? _____
- L. Is the symptom worse at certain times of the day or night? (circle one)
- Morning Afternoon Evening Night Unaffected by time of day

Symptom 3

M. On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

N. What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one) suddenly _____ gradually _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

O. Describe how the symptom feels (circle all that apply):

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Other (please describe): _____

P. Does the symptom move to another part of your body (circle one): yes no

- If yes, where does the symptom move? _____

Q. Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 4

R. On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

S. What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one) suddenly _____ gradually _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

T. Describe how the symptom feels (circle all that apply):

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Other (please describe): _____

U. Does the symptom move to another part of your body (circle one): yes no

- If yes, where does the symptom move? _____

V. Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 5

W. On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

X. What percentage of the time you are awake do you experience the above symptom at the above intensity:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one) suddenly _____ gradually _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

Y. Describe how the symptom feels (circle all that apply):

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Other (please describe): _____

Z. Does the symptom move to another part of your body (circle one): yes no

- If yes, where does the symptom move? _____

AA. Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 6

BB. On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
1 2 3 4 5 6 7 8 9 10

CC. What percentage of the time you are awake do you experience the above symptom at the above intensity:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one) suddenly _____ gradually _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

DD. Describe how the symptom feels (circle all that apply):

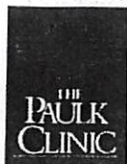
- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
- Other (please describe): _____

EE. Does the symptom move to another part of your body (circle one): yes no

- If yes, where does the symptom move? _____

FF. Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day



Authorizations and Releases

Terms of Acceptance: The practice of chiropractic in this office consists of detecting and correcting spinal misalignments. It is the clinical goal of this office to attempt to restore the proper biomechanics of the spine and minimize pathological stress on spinal tissues, as well as maximizing the inherent recuperative powers of the body. I understand that the purpose of chiropractic care in this office is to attempt to restore the biomechanical integrity of the spine, and not to "treat" or "cure" specific diseases/conditions.

Signed: _____ Date: _____

Release of medical records: I hereby authorize and direct any physician or surgeon who has treated me and any hospital at which I have been examined to provide any and all information that may have been acquired in the course of such treatment to: Paulk Clinic 9905 N. Davidson Parkway, Suite 107 Stockbridge, GA 30281. Furthermore, I authorize Paulk Clinic at said address to furnish my medical records to my attorney, insurance company, and other interested parties a full report of examination, diagnosis, treatment, prognosis, etc. A Photostat copy of this authorization shall be considered valid and as effective as the original.

Signed: _____ Date: _____

Assignment of Benefits: I hereby authorize my insurance company to make payments directly to: Paulk Clinic 9905 N. Davidson Parkway, Suite 107 Stockbridge, GA 30281. I understand that insurance policies are an arrangement between the insurance provider and myself and that this office will assist in the preparation of necessary documentation and that **I am personally responsible for payment of charges for services rendered.**

Signed: _____ Date: _____

Patient Pregnancy Disclaimer: This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction, that I understand the clinical necessity for having X-Rays taken at this time, and that I hereby give permission for this procedure. In doing so, I release the doctor from responsibility for any potential damage arising from this procedure.

Signed: _____ Date: _____

At this time I am sure that I am not Pregnant.

Signed: _____ Date: _____

Consent to treat a minor: I hereby verify that I am the legal custodian/ legal guardian of _____ and grant permission to Paulk Clinic 9905 N. Davidson Parkway, Suite 107 Stockbridge, GA 30281 to perform the necessary examination, X-Rays, diagnosis, and treatment of the afore named minor.

Signed: _____ Date: _____