



## PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female E-mail: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Other

Name of spouse or nearest relative: \_\_\_\_\_ Phone \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Your Employer: \_\_\_\_\_

Referred to this office by:  Friend/Family member – Name? \_\_\_\_\_

Yellow pages  Mail  Sign  Other \_\_\_\_\_

Payment for services will be by:  Cash  Check  Credit Card  Health Insurance

Automobile Insurance  Worker's Compensation

Name of Insurance Company: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's Social Security #: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_

Are you covered by more than one insurance company?  Yes  No Name: \_\_\_\_\_

### 1. GENERAL SYMPTOMS: Fill in ALL boxes that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="radio"/> Asthma (493.0)              | <input type="radio"/> HIV/ARC                   | <input type="radio"/> Numbness              | <input type="radio"/> Stress (308.9)  |
| <input type="radio"/> Bladder Trouble             | <input type="radio"/> Jaw Pain (524.60)         | <input type="radio"/> Obesity (278.0)       | <input type="radio"/> Tuberculosis    |
| <input type="radio"/> Bowel Control Loss          | <input type="radio"/> Kidney Disorder           | <input type="radio"/> Hepatitis             | <input type="radio"/> Vertigo (386.0) |
| <input type="radio"/> Cancer                      | <input type="radio"/> Loss of Sleep (780.52)    | <input type="radio"/> PMS (625.4)           | <input type="radio"/> Other           |
| <input type="radio"/> Chest Pain (786.5)          | <input type="radio"/> Menstrual Cramps          | <input type="radio"/> Poor Circulation      | <input type="radio"/> Other           |
| <input type="radio"/> Diabetes (250.0)            | <input type="radio"/> Multiple Sclerosis        | <input type="radio"/> Rheumatism            | <input type="radio"/> Other           |
| <input type="radio"/> Fatigue (780.79)            | <input type="radio"/> Muscular Dystrophy        | <input type="radio"/> Scarlet Fever         | <input type="radio"/> Other           |
| <input type="radio"/> High Blood Pressure (401.9) | <input type="radio"/> Nervous/Irritable (799.2) | <input type="radio"/> Sinus Trouble (461.9) |                                       |

Have you been treated by a physician in the last year?  Yes  No

Describe condition: \_\_\_\_\_ Date of last physical exam? \_\_\_\_\_

### SURGICAL/ACCIDENT HISTORY:

1. \_\_\_\_\_ Date: \_\_\_\_\_  job  auto  other Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_  job  auto  other Date: \_\_\_\_\_



PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**7. ARM: Fill in ALL boxes and circle all numbers that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.**

- Pain (719.42) – (1) *Left Side* (2) *Right Side* (3) *Both*  Other
- Stiffness (719.52) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Osteoarthritis (715.12) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Numbness/Tingling (782.0) – (1) *Left Side* (2) *Right Side* (3) *Both*

**8. ELBOW: Fill in ALL boxes and circle all numbers that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.**

- Pain (719.43) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Stiffness (719.53) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Osteoarthritis (715.13) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Tennis Elbow (726.32) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Numbness/Tingling (782.0) – (1) *Left Side* (2) *Right Side* (3) *Both*

**9. WRIST: Fill in ALL boxes and circle all numbers that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.**

- Pain (19.44) – (1) *Left Side* (2) *Right Side* (3) *Both*  Other
- Stiffness (719.54) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Osteoarthritis (715.14) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Carpal tunnel Syndrome (354.0) – (1) *Left Side* (2) *Right Side* (3) *Both*

**10. HAND: Fill in ALL boxes and circle all numbers that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.**

- Pain (719.44) – (1) *Left Side* (2) *Right Side* (3) *Both*  Other
- Stiffness (719.54) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Osteoarthritis (715.14) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Carpal Tunnel Syndrome (354.0) – (1) *Left Side* (2) *Right Side* (3) *Both*

**11. THIGH/HIP: Fill in ALL boxes and circle all numbers that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.**

- Pain (719.45) – (1) *Left Side* (2) *Right Side* (3) *Both*  Other
- Stiffness (719.55) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Osteoarthritis (715.15) – (1) *Left Side* (2) *Right Side* (3) *Both*

**12. LEG: Fill in ALL boxes and circle all numbers that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.**

- Pain (719.46) – (1) *Left Side* (2) *Right Side* (3) *Both*  Other
- Stiffness (719.56) – (1) *Left Side* (2) *Right Side* (3) *Both*
- Osteoarthritis (715.16) – (1) *Left Side* (2) *Right Side* (3) *Both*

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**13. ANKLE: Fill in ALL boxes and circle all numbers that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.**

- Pain (719.47) – (1) *Left Side* (2) *Right Side* (3) *Both*  Other  
 Stiffness (719.57) – (1) *Left Side* (2) *Right Side* (3) *Both*  
 Osteoarthritis (715.17) – (1) *Left Side* (2) *Right Side* (3) *Both*

**14. FOOT: Fill in ALL boxes and circle all numbers that apply OR if this section does not apply to your health history, check here \_\_\_\_\_ and go to the next section.**

- Pain (719.47) – (1) *Left Side* (2) *Right Side* (3) *Both*  Other  
 Stiffness (719.57) – (1) *Left Side* (2) *Right Side* (3) *Both*  
 Osteoarthritis (715.17) – (1) *Left Side* (2) *Right Side* (3) *Both*

**SYMPTOMS ARE WORSE IN THE**  Morning  Afternoon  Evening  Night  
When & how occurred? \_\_\_\_\_

Symptoms developed from:  Job Related Injury  Auto Accident  Other Accident

Symptom onset:  Unknown Cause  Gradual Onset  Immediate Onset

Symptoms have persisted for # \_\_\_\_\_  Hours  Days  Weeks  Months  Years

Have you ever had this before?  No  Yes When? \_\_\_\_\_

If you were to guess, what do you think is causing your complaints? \_\_\_\_\_

Have you seen any other doctors for this condition? \_\_\_\_\_ Name of Dr.? \_\_\_\_\_

Are you allergic to any medications?  No  Yes What kind? \_\_\_\_\_

Are you taking any medications?  No  Yes What kind? \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR PAIN:**

- Bending  Sitting  Stretching  Resting  Lying Down  Standing  Walking  
 Heat  Ice  Massage  Adjustments  Pain Medications  Muscle Relaxers/Anti-inflammatories

**PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE HAVING:**

- Blurred Vision  Cold Hands/Feet  Constipation  Depression  Dizziness  Fatigue  
 Fever  Head Seems Too Heavy  Headaches  Insomnia  Light Sensitivity  Loss of Balance/Smell/Taste  
 Numbness Fingers/Toes  Pins & Needles  Other \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



# FINANCIAL POLICY

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

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## THE FOLLOWING POLICIES ARE IMPORTANT TO ENSURE PAYMENT.

1. Insurance co-pays, insurance deductibles, cash patient fees and massage fees are expected at the time services are rendered. A payment plan will be set up if needed.
2. Checks, cash and credit cards are accepted.
3. If you would like to file with your insurance company, we will give you a receipt for services rendered. If you would like us to file you with your insurance company, we will do so.
4. Your appointment is set aside just for you. Please give us 24 hour notice if cancellation is necessary, so that someone else can be scheduled. If you do not give 24 hour notice, you will be charged \$25.00 for the missed appointment.
5. All services rendered are ultimately the patient's responsibility. Any balance that remains after the patients insurance has made payment and any unpaid balance that remains 60 days after services are rendered must be paid by patient.
6. To ensure proper scheduling of appointments for massage and to be especially mindful of the needs of other clients. The massage session times are as follows: Ninety minute session is 85 minutes, a one hour session is 55 minutes and a thirty minute session is 25 minutes. This allows for dressing time after the massage. If you arrive late for your massage appointment, you will have the remainder of the time that you are scheduled for, but will be charged for the entire session. Example: Your appointment is scheduled for 10:00-11:00 it will end at 10:55. If you arrive at 10:15, the massage will still end at 10:55, and you will be expected to pay for the entire hour.
7. We require a credit card to be on file. Your credit card will only be billed after we have notified you of your balance due and no other payment arrangements have been made and received.

## I HAVE READ THE ABOVE POLICIES AND AGREE TO ALL TERMS.

\_\_\_\_\_  
Name printed on credit card

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Credit Card Number

\_\_\_\_\_  
Expiration date

\_\_\_\_\_  
Card type: Visa, MC, Amex or Discover



**LAKE POINTE**  
CHIROPRACTIC

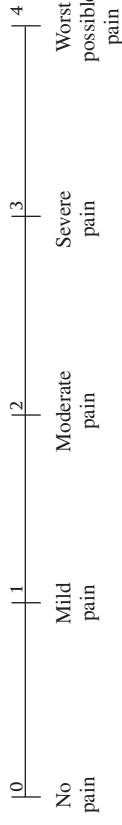
# FUNCTIONAL RATING INDEX

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

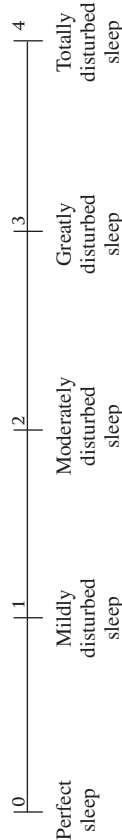
## FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY.

In order to properly assess your condition, we must understand how much your neck/back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

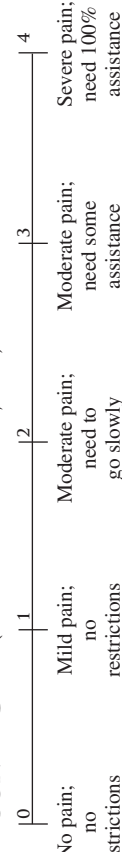
### 1. PAIN INTENSITY



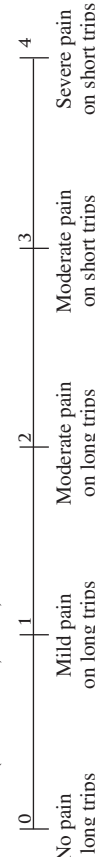
### 2. SLEEPING



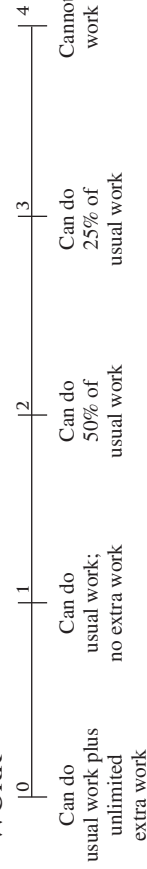
### 3. PERSONAL CARE (WASHING DRESSING, ETC.)



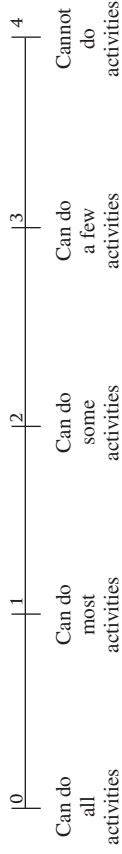
### 4. TRAVEL (DRIVING, ETC.)



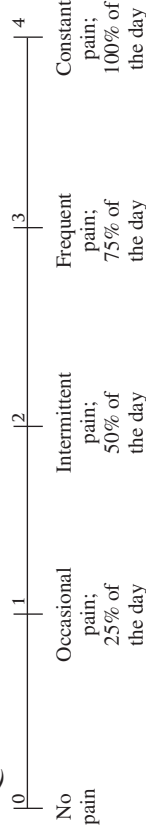
### 5. WORK



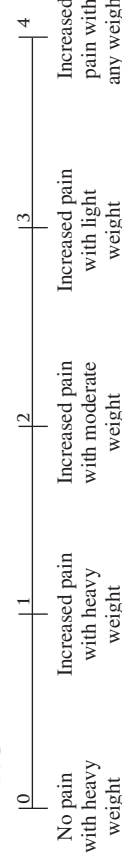
### 6. RECREATION



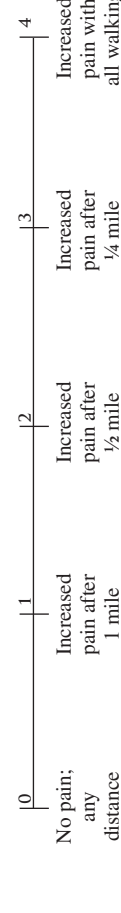
### 7. FREQUENCY OF PAIN



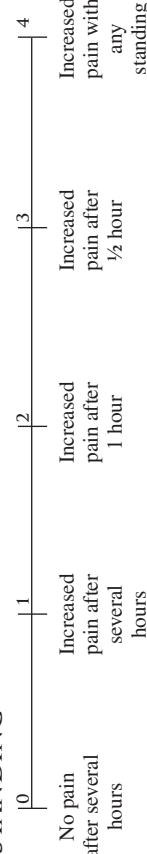
### 8. LIFTING



### 9. WALKING



### 10. STANDING



NAME \_\_\_\_\_

PRINTED

ID#SS# \_\_\_\_\_

PLAN ID \_\_\_\_\_

TOTAL SCORE \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_





# INSURANCE INFORMATION

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

PATIENT NAME \_\_\_\_\_ SS # \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX:  M  F MARITAL STATUS:  M  D  S  W

EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_

INSURED'S DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

PHONE \_\_\_\_\_ EXT \_\_\_\_\_

## EMPLOYEE TYPE:

- RETIRED
- EMPLOYED FULL TIME
- EMPLOYED PART TIME
- NOT EMPLOYED
- SELF EMPLOYED
- STUDENT

PRIMARY INSURANCE CO. \_\_\_\_\_ ID# \_\_\_\_\_

SECONDARY INSURANCE CO. \_\_\_\_\_ ID# \_\_\_\_\_

WORK RELATED INJURY?  YES  NO IF YES DATE OF INJURY \_\_\_\_\_

ACCIDENT RELATED INJURY?  YES  NO IF YES DATE OF INJURY \_\_\_\_\_

\_\_\_\_ INSURANCE ASSIGNMENT – I authorize payment of medical benefits from \_\_\_\_\_ insurance company to be paid directly to: LAKE POINTE CHIROPRACTIC, Inc. for services rendered to me. If my current policy prohibits the direct payment to the doctor, then I also instruct and direct you to make out the check to me and mail it to LAKE POINTE CHIROPRACTIC, Inc. I also acknowledge that all services rendered to me are ultimately my financial responsibility. I agree to pay any balance that remains after my insurance company has made payment, and any unpaid balance that remains 60 days after services are rendered.

\_\_\_\_ CASH POLICY – I do not have insurance benefits available and agree to pay for all services rendered to me, at the time they incur, unless otherwise agreed to in the form of a financial payment contract.

\_\_\_\_ Records release – I hereby authorize the release of my x-rays and medical records from any medical provider, hospital, attorney, or insurance company upon receipt of a copy of this form, to LAKE POINTE CHIROPRACTIC, Inc.

\_\_\_\_ AUTHORIZE TO RELEASE INFORMATION – I authorize LAKE POINTE CHIROPRACTIC, Inc. to release any information you deem appropriate concerning my condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me in this medical office. I hereby release you from any consequences thereof.

\_\_\_\_ CONSENT TO TREAT – I hereby give my consent for LAKE POINTE CHIROPRACTIC, Inc. to examine and render treatment to \_\_\_\_\_.

**I have read the above blanket authorization/release form and agree to the 5 items checked off.**

## RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



# LOW BACK PAIN QUESTIONNAIRE

PATIENT NAME (PRINT): \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

This questionnaire is designed to enable us to understand how much your low back pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

### PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

### STANDING

- I can stand as long as I want without pain.
- I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than ten minutes without increasing pain.
- I avoid standing, because it increases the pain straight away.

### PERSONAL CARE (WASHING, DRESSING, ETC.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing or dressing without help.

### SLEEPING

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than one than one quarter.
- Because of pain, my normal night's sleep is reduced by less than one-half.
- Because of my pain, my normal night's sleep is reduced by less than three-quarters.
- Pain prevents me from sleeping at all.

### LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights, at the most.

### SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

### WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk while using a cane or on crutches.
- I am in bed most of the time and have to crawl to the toilet.

### TRAVELING

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

### SITTING

- I can sit in any chair as long as I like without pain.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

### CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.



# NECK PAIN QUESTIONNAIRE

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

PATIENT NAME (PRINT): \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

This questionnaire is designed to enable us to understand how much your low back pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

## PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

## CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

## PERSONAL CARE (WASHING, DRESSING, ETC.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

## WORK

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

## LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

## DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

## READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

## SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

## HEADACHES

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

## RECREATION

- I am able to engage in all of my recreational activities with no neck pain at all.
- I am able to engage in all of my recreational activities with some pain in my neck.
- I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- I am able to engage in a few of my recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.



# NEUROLOGICAL & VASCULAR PATIENT QUESTIONNAIRE

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

FOR ANY **YES** ANSWER, PLEASE NOTIFY THE DOCTOR:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands?  NO  YES  
Comment: \_\_\_\_\_
2. Do you have weakness, numbness or burning in your shoulder, arms or hands?  NO  YES  
Comment: \_\_\_\_\_
3. Do your hands or arms fall asleep regularly?  NO  YES  
Comment: \_\_\_\_\_
4. Do you have reduced feeling (sensation) or swelling in your hands or arms?  NO  YES  
Comment: \_\_\_\_\_
5. Do you suffer from a loss of hand grip strength?  NO  YES  
Comment: \_\_\_\_\_
6. Do you suffer from back pain with pain in your buttocks, legs or feet?  NO  YES  
Comment: \_\_\_\_\_
7. Do you have weakness, numbness or burning in your buttocks, legs or feet?  NO  YES  
Comment: \_\_\_\_\_
8. Do your legs or feet fall asleep regularly?  NO  YES  
Comment: \_\_\_\_\_
9. Do you have reduced feeling (sensation) or swelling in your legs, feet?  NO  YES  
Comment: \_\_\_\_\_
10. Do you suffer from cold hands or feet?  NO  YES  
Comment: \_\_\_\_\_
11. Do you suffer from headaches, dizziness or memory loss?  NO  YES  
Comment: \_\_\_\_\_
12. Do you have difficulty maintaining your balance?  NO  YES  
Comment: \_\_\_\_\_
13. Do you suffer from vertigo or blurred vision?  NO  YES  
Comment: \_\_\_\_\_
14. Do you suffer from a reduced hearing capacity?  NO  YES  
Comment: \_\_\_\_\_
15. Do you suffer from ringing in your ears?  NO  YES  
Comment: \_\_\_\_\_
16. Do you smoke?  NO  YES  
Comment: \_\_\_\_\_

**IF YOU ANSWER **YES** TO ANY OF THE ABOVE QUESTIONS, GIVE THIS FORM DIRECTLY TO YOUR DOCTOR, HE OR SHE CAN HELP!**

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices.



# OFFICE POLICIES & PROCEDURES

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

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- \_\_\_ **1. SYMPTOMS:** Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.
  
- \_\_\_ **2. APPOINTMENTS:** A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule it within 24 hours so you stay on target for wellness. It is your responsibility to get here. We will do all we can do to accommodate you.
  
- \_\_\_ **3. DAILY VISIT PROCEDURES:** Each time you arrive for your appointment, sign in at the reception desk and have a seat in the waiting room until you are directed into an adjusting room by the front desk assistant. Go to the adjusting room and lay down on your stomach and relax until the doctor becomes familiar with your spine to adjust it. Once your doctor becomes familiar with your spine, your adjustments will only take a few minutes and will be very focused. Please help keep things moving smoothly by laying down on the table quietly and relaxing for your adjustment. Our open environment allows you to receive your care quickly and efficiently with minimal waiting.
  
- \_\_\_ **4. DYNAMIC EVALUATIONS:** During your initial corrective care you may receive several dynamic evaluations to monitor your level of spinal correction. On this visit you will fill out an update form and will be retested on all of your initial findings. Plan on spending an extra 30 minutes on these days. There is an additional fee for this visit unless you are on a prepayment plan that is all inclusive. Your doctor will sit down to discuss the results of this exam. At the end of your corrective adjustment plan, you will receive recommendations for a wellness adjustment plan to help you stay as healthy as possible.
  
- \_\_\_ **5. EXERCISE:** Many people try to correct their spine with exercise. Research shows that people that exercise on an injured spine, that has healed improperly, will tend to experience more rapid deterioration of their spinal bones, discs, and nerves. However, when you exercise in conjunction with your Chiropractic Adjustments, you will find that your spine will improve more quickly and your athletic performance will be dramatically enhanced. We recommend that you do some type of aerobic exercise, such as walking at least once a day.
  
- \_\_\_ **6. NUTRITION:** Good nutrition is important to maximize your health and healing capacities. A diet filled with fresh water, fruit and vegetables will fulfill your nutritional needs on a daily basis. For more detailed information on nutrition ask your doctor.
  
- \_\_\_ **7. RESULTS:** We are very results oriented, however many factors that we have no control over may affect how quickly you respond to your care. These include your age, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to wellness care as quickly as possible.

PATIENT: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_\_\_

***Congratulations on choosing chiropractic. Follow through with your family, and enjoy the health benefits that come with a chiropractic lifestyle.***



# PRIVACY NOTICE ACKNOWLEDGEMENT

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

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We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of **LAKE POINTE CHIROPRACTIC, LLC** Notice of Privacy Practices for Practices for Protected Health Information.

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PATIENT NAME PRINTED

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DATE

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PATIENT SIGNATURE

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PERSONAL REPRESENTATIVE PRINTED

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PERSONAL REPRESENTATIVE SIGNATURE

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DESCRIPTION OF PERSONAL REP'S AUTHORITY TO ACT FOR THE PATIENT



# AUTHORIZATION TO PERFORM X-RAYS

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

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DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ A.M. / P.M.

I have been informed by the doctors at Lake Pointe Chiropractic that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem or illness.

I authorize the doctors at Lake Pointe Chiropractic to perform such radiographic examination necessary to diagnose and administer whatever is deemed necessary to treat my present problem or illness.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS

To the best of my knowledge, I am **NOT** pregnant and the doctors at Lake Pointe Chiropractic have my permission to x-ray me for diagnostic interpretation.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

I understand that Lake Pointe Chiropractic, in order to assure the best results possible, requires \_\_\_\_\_ more x-rays at a total cost of \$ \_\_\_\_\_. This charge is subject to any insurance limitations and are expected to be paid in full at time of service.

\_\_\_\_\_  
SIGNATURE



# X-RAY DECLINE

LAKE POINTE CHIROPRACTIC | 3950 COBB PKWY SUITE 401 | ACWORTH, GA 30101

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I have been informed by the doctor's at Lake Pointe Chiropractic that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem or illness.

I hereby decline diagnostic x-rays and understand the possibility of incomplete diagnosis due to my choice.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE