CAPSTONE CHIROPRACTIC

LEANNE M. SMITH, D.C.
DANIEL H. TEW, D.C.

480 North Main Street, Suite 201
Alpharetta, GA 30009
(770) 864-1195

WELCOME TO OUR OFFICE

We want to ***Thank You*** for trusting your health with us. We understand patients that have a superior understanding of how GOD created the body get the best results. The foundation of understanding is EDUCATION. Over the next visits, and in fact, throughout the course of our relationship with you and your family we place education as one of our primary objectives. If you should ever have any questions regarding anything pertaining to your care or if you ever need something explained, stop us.

If you came into the office because of a promotion or advertisement please let one of our team members know when you are done signing below. As with any promotion or advertisement, additional services are not included after initial offer. ***Thank You*** for choosing **Capstone Chiropractic** for your way to better health. We love and appreciate you....Welcome to our Family!

Signed:______________________________ Date:_____________

WELCOME TO OUR OFFICE!

<u>This is what you may receive today:</u>

*All below are *as needed*, depending on the individual

1.) Chiropractic Examination

2.) Posture Analysis

3.) Digital Spinal Imaging

4.) Spinal X-rays

** I have read the above and understand what I will receive. **

______________________________________ ___________
Patient's Signature Date

** Additional services not included **

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PATIENT INFORMATION---Please Print

GENERAL INFORMATION

Patient Last Name ________________________ First Name ________________________
Address ________________________ Care of ________________________
(Parent or financially responsible person)
City ____________ State ______ Zip Code ______ Phone (Home) ____________
Driver's License # ________________ No. Children ______ Phone (Work) ____________
Email Address ________________ Cell Phone ____________

Sex M F	Married Single Widowed Divorced	Age	Date of Birth / /	Social Security Number -- --

Employer's Name ________________________
Address ________________________
City ____________ State ______ Zip Code______
Phone ____________ Occupation ____________

Spouse's Name ____________ Spouse's Employer ____________
Spouse's Date of Birth ____________

EMPLOYED
Full Time Part Time
Retired Not Employed

STUDENT
Full Time Part Time
Non-Student

REFERRED BY: ________________________

INSURANCE INFORMATION

Primary Insurance Company Name ____________________ Insured's Name ____________ ID/Membership # ____________ Policy/Group # ____________ Provider Customer Service Phone ____________	***Complete only if patient is not the insured*** Patient's Relationship to Insured ____________ Insured's Date of Birth _____/_____/______ Insured's Employer ____________
Secondary Insurance Company Name ____________________ Insured's Name ____________ ID/Membership # ____________ Policy/Group # ____________ Provider Customer Service Phone ____________	***Complete only if patient is not the insured*** Patient's Relationship to Insured ____________ Insured's Date of Birth _____/_____/_____ Insured's Employer ____________

Are you seeing the Doctor today due to a:
(If yes, please inform the front desk)
Work-Related Injury? Yes___ No ___ Date of Injury ____________

Auto Accident? Yes ___ No ___ Date of Injury ____________

RELEASE AND ASSIGNMENT

I agree to treatment by my doctor and such persons of the doctor's choosing, which may include interns, preceptors, Chiropractic Assistants, etc and hereby provide my consent for treatment.
Patient's Signature ________________________ Date ____________

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my chiropractor.
Patient's Signature ________________________ Date ____________

I understand that Capstone Chiropractic will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.
Patient's Signature ________________________ Date ____________

PATIENT HISTORY/EXAMINATION FORM

________________________**Complete ALL questions below** ______________________________

1. What are your **major complaint(s)/illnesses?**____
____

2. What are your **minor complaint(s)/illnesses?**____
____

3. How **long** have you been experiencing your major complaint? □ Days □ Weeks □ Months □ Years

Mechanism of Injury

4. What was the **cause** of your major complaint (how did it happen)?
____
____

5. **When** did you first experience your major complaint? ____

6. What have you done **prior** to coming to this office to treat your major and minor complaints?
____
____

7. When do you **notice** your complaint or complaints the most? □ AM □ PM □ BOTH

8. How long does it last? __________Minutes __________Hours

9. What makes it feel **worse**? □ Sitting □ Standing □ Lying □ Activity □ Other______________

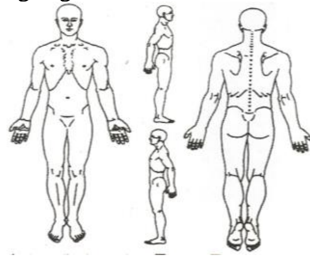
10. What makes it feel **better**? □ Sitting □ Standing □ Lying □ Activity □ Drugs □ Other______________

11. What best describes the character and quality of your major illness or pain?

A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain

12. Have you ever had this problem in the past? □ Yes □ No

13. On the diagram below, please **show** where you are experiencing all of your present complaints using the following letters: A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain



14. On the scale below, please **circle** the **severity and intensity** of your **main complaint** (at its' worst):

None **Slight** **Mild** **Moderate** **Severe**

1	2	3	4	5	6	7	8	9	10

15. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:

Occasional **Intermittent** **Frequent** **Constant**

10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

16. Does your pain radiate? _____Y ______N Where does it radiate to? _________________________________

Signature ____ **Date** ____________________________

Patient History

Please check (x) all present and past symptoms.

HEAD:
___Headache
___Sinus
___Entire head
___Back of head
___Forehead
___Temples
___Migraine
___Loss of memory
___Light-headed
___Fainting
___Light bothers eyes
___Blurred vision
___Double vision
___Loss of vision
___Loss of balance
___Loss of taste
___Loss of hearing
___Dizziness
___Pain in ears
___Ringing or noises in ears

NECK:
___Pain in neck
___Sharp
___Dull
___Ache
___Neck pain with movement
___Forward
___Backward
___Turning (L) (R)
___Bending (L) (R)
___Pinched nerve in neck
___Neck feels out of place
___Muscle spasms in neck
___Grinding sounds in neck
___Popping sounds in neck

SHOULDERS:
___Pain in joint (L) (R)
___Pain across shoulders
___Arthritis (L) (R)
___Can't raise arm
___Above shoulder level
___Over head
___Tension in shoulders
___Pinched nerve in shoulder (L) (R)
___Muscle spasms in shoulder

ARMS AND HANDS:
___Pain in arm
___Tennis elbow
___Pain in hands/fingers (L) (R)
___Pins and needles sensation (L)(R)
___Numbness (L) (R)
___Hands cold
___Loss of grip strength
___Sore/swollen joints in fingers

MIDBACK:
___Mid-back pain
___Pain between shoulder blades
___Sharp stabbing
___Dull ache
___Muscle spasms

CHEST:
___Chest pain
___Shortness of breath
___Rib pain
___Breast pain
___Irregular heartbeat

ABDOMEN:
___Nervous stomach
___Foods can't eat___________
___Nausea
___Gas
___Constipation
___Diarrhea
___Hemorrhoids

LOW BACK:
___Lower back pain
___Sharp
___Dull
___Ache
Location:
___Upper lumbar
___Lower lumbar
___Hip
___Low back pain is worse when
___Working
___Lifting
___Stooping
___Standing
___Sitting
___Bending
___Coughing
___Lying down
___Walking
___Pain relieved when_________
___Slipped disc
___Low back feels out of place
___Muscle spasms

HIPS, LEGS & FEET:
___Pain in buttocks (L) (R)
___Pain in hip joint (L) (R)
___Pain down leg (L) (R)
___Knee pain (L) (R)
___Outside
___Inside
___Leg cramps
___Feet cramps
___Pins and needles in legs
___Numbness in legs/feet
___Swelling in legs/feet

WOMEN ONLY:
___Menstrual pain
___Cramping
___Irregularity
___Cycle ___Days
___Birth control __________type
___Hysterectomy
___Tumors/Cancer_________
___Discharge
___Menopause
___Abortions
___Are you pregnant

MEN ONLY:
___Urinary frequency
___Difficulty urination
___Night urination
___Prostate swelling

GENERAL:
___Nervousness
___Irritable
___Depressed
___Fatigue
___Run-down feeling
___Normal sleep _______hrs
___Loss of sleep
___Loss of weight _______lbs
___Weight gain _________ lbs
___Coffee _______cups/day
___Tea _______cups/day
___Cigarettes _______pack/day
___Diabetes
___Hypoglycemia

OTHER ____________________________
____

Medications: ________________________
____
____
____

Signature: ____________________________________ **Date:** ______________________

POLICIES

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. X-rays are the property of this office and are used for treatment purposes. A digital copy of your x-rays may be requested at any time. Please note that all records request may take up to thirty days to complete.

3. Method of payment you plan to use to take care of today's charges? (Please check one choice)

☐ CASH ☐ CHECK ☐ VISA/MASTERCARD/DISCOVER

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Capstone Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Capstone Chiropractic will be credited to my account upon receipt. **However**, I clearly understand and agree that all my services rendered me are charged directly to me and that I am responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. If an account balance remains unpaid for three months or longer, a monthly interest fee of 2% will apply to account balance. I authorize Capstone Chiropractic to obtain a credit report if deemed necessary.

Please Note:
This will be our only notice to you. Due to our efforts to keep costs down and control our outstanding accounts, all accounts over 30 days past due are subject to collection agency procedures and additional costs.

Patient Signature____ Date____________________

Guardian Signature Authorizing Care_______________________________ Date____________________

EMERGENCY CONTACT INFORMATION: *[Please list someone OUTSIDE OF YOUR HOME---Thank you!!]*

In case of emergency, please notify____

Relationship____

Address ____
____
____

Phone # ____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion and disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____ ________________________
Signature Date

FEMALES ONLY:

Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period ________________________________.

____ ________________________
Signature Date