NEW PATIENT INTAKE

Name: _____

Today's Date: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Would you prefer Text OR Email Reminders?
Cell Provider: _____
Email Address: _____ Male: __ Female: __ SSN: _____
Birth Date: ___ / ___ / _____ Age: ____ Occupation: _____
Employer Name & Address : _____
Marital Status : _____ Spouse's Name (if applicable) : _____

Have you been treated by a chiropractor before? (Please Circle) YES NO
If yes, where? _____ Who may we thank for referring you to our office? _____

Insurance Information:
Name of Policy Holder: _____ Relation to Patient: _____
Policy Holder Date of Birth: ____ / _____ / _____

Your Health Summary

Please check all symptoms you have ever had, even if they do not seem related to your current problem

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting
☐ Pins & Needles in Arms	☐ Loss of Smell	☐ Back Pain
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears
☐ Numbness in Fingers	☐ Numbness in Toes	☐ Loss of Taste
☐ Sleeping Problems	☐ Depression	☐ Irritability
☐ Fatigue	☐ Lights Bother Eyes	☐ Cold Hands
☐ Diarrhea	☐ Neck Stiff	☐ Fever
☐ Cold Sweats	☐ Constipation	☐ Problem Urination
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity
☐ Neck Pain	☐ Loss of Balance	☐ Nervousness
☐ Stomach Upset	☐ Tension	☐ Cold Feet
☐ Hot Flashes	☐ Heartburn	☐ Ulcers

Family History of any of the above:

_____

_____

List any Medications you are Taking:

_____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

These statements made on this form are accurate to the best of my recollection and I consent for this office to examine me for further evaluation.

- I authorize payment of medical benefits to this office. Fees may be applied to balances over 90 days.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination for documentation purposes, if necessary.
- I allow this office to contact me via email, text message, or phone for scheduling and clinical need.
- I authorize Savannah Hills Family Chiropractic to securely store my credit card information and to process payments on that stored card.
- This office occasionally sends email newsletters and updates to keep patients informed. I understand that I may opt-out through the email itself.
- I give this office the right to use my name for any office promotions or publications (within HIPAA guidelines).
- I understand that this authorization may be denied or retracted by notifying the office manager in writing.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date:_____

It's not about the pain. It's all about what you will do when the pain is gone.

What do you have planned?

Savannah Hills Family Chiropractic

200 Creekstone Ridge, Woodstock, GA 30188 770-592-1909

Richard Schones, D.C.

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:Witness

Name: _____ Signature: _____ Date:

CONSENT TO TREAT MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of _____ a minor, do hereby authorize SAVANNAH HILLS CHIROPRACTIC CENTRE as agent(s) for the undersigned to consent to any x-ray, examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements or this authorization, may in exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until the child comes of age (18 years of age).

Date:_____

Signature:_____

PLEASE CIRCLE RELATIONSHIP: PARENT
LEGAL GUARDIAN
PERSON HAVING LEGAL CUSTODY