Patient Intake Form

Welcome to our office! Thank you for taking a moment to fill in our Patient Intake Form. Please fill this form out completely and to the best of your knowledge. Let our staff know if you have any questions. Once completed please return completed forms to our office with the Authorization Agreement box checked and paper work signed.

Patient Information

First Name:	Middle	Name:	_Last Name:
ssn#:	Birthday:	Height:	Weight:
Sex: FO MO			me:
Home #:	Work #:	Cell #:	Preferred Contact #:
E-mail:		Who were you Referred	by:
Address:			
			Zip:
Employer Inform	ation		
Employed: Full 1	Time Part-time H	ome-maker Unemploye	10.5%
			d Retired
			Employer Zip:
			Supervisor# :
Physical Work Duties		_ work supervisor:	Supervisor# :
History			
List Current Medicati	lons:		
(Name, Amounts, Fre	equency or attach copy of me	dication list)	

History Continued

Have You Ever:		
Broken Bones:	○Yes ○No	Treatment: O Yes O No Explain:
Sprains/Strains:	○Yes ○No	Treatment: Yes No Explain:
Hospitalized:	○Yes ○No	Explain:
Surgery:	○Yes ○No	Explain:
Auto Accident:	○Yes ○No	Treatment: Yes No Explain:
Struck Unconscious	: O Yes O No	Treatment: Yes No Explain:
Eating Disorder:	○Yes ○No	Explain:
Stroke:	○Yes ○No	Explain:
Family History:		
	Cancer, Diabetes,	Heart Disease, Kidney Disease, High Cholesterol, etc.
	Viole	
		Home Injury O Job O Chronic Discomfort O Other O
When did this conc	ern begin?	
Has this concern?	Gotten Worse 🔘 :	Stayed Constant O Come and Gone
		Work Sleep Daily Routine Other Activities
Briefly explain:		
Has this concern oc	curred before?	Yes O No Briefly explain:

Have you seen Other Doctors for this concern? OYes O No Doctors Name:

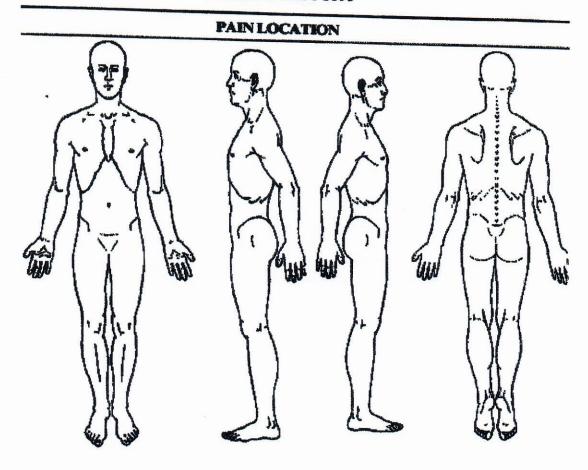
Type of Treatment:

Results: Good Bad Indifferent

Women

	f the insured:
Check t	his circle: O I agree with this statement of authorization.
or term	ce companies and me. I understand that fees for professional services will become immediately due upon suspensio Ination of my care or treatment.
baliner	of such services, I understand and agree that health/accident insurance policies are an arrangement between
	to the charged to me and t
atter Pen	mounted by me. I grant the use of my signed statement of authorization with my signed use for account of the
1 GIEGGE	all illior Hation necessary to any insurance company afformaty or adjusted for the manager of the second of the se
l author	ize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor t
Oi Cillio	practic.
be true	and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office
I certify	that I am the patient or legal guardian listed above. I have read/understand the included information and certify it i
Autho	rization
O Yes (
Chiropr	actic is the largest natural healing profession in the world?
○ Yes () No
The ner	yous system controls all bodily functions and systems?
O Yes (
Doctors	of Chiropractic work with the nervous system?
Were	you aware that
chiropra	prehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible wit actic & nutritional counseling.
O Corre	ective Care: Correcting and relieving the cause of the problem as well as the symptoms.
Relie	f Care: Symptomatic relief of pain or discomfort.
Check t	ne appropriate concerns for care:
correcti your ne	see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for on of whatever is malfunctioning in their body. Your doctor will tailor your recommended care program based of Bds and desires.
People:	186 a Chiropractor for a ventety of
Goals	for Your care
Are you	nursing? Yes No Do you have breast implants? Yes No Do you experience painful periods? Yes N
	pregnant? Yes No Are you taking birth control? Yes No Do you have irregular cycles? Yes No

PATIENT HISTORY



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience Pain
NNN	Where you experience Numbness
TTT	Where you experience Tingling
BBB	Where you experience Burning
CCC	Where you experience Cramping

PATIENT SIGNATURE	DATE	
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PATHWAYS TO HEALING 1022 Founders Row Greensboro, Georgia 30642 (706) 454-2040 Fax (706) 454-2050

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risks. I wish to rely on the doctor to exercise which the doctor feels at the time, based on	formance of chiropractic adjustments or other rstand that as in all health care there are some he doctor to be able to anticipate or explain all judgment during the course of the procedure the facts at the time, are in my best interest.
Appointments are required if you are to	te you may have to wait for the next available
Keeping your appointment	nportant. Frequency of visits count. Therefore is
This is a fee for service office. Payment is cash, checks, Visa, Discover, MasterCard and checks. There is a fee charged for any report: may not carry a balance at any time.	expected when services are rendered. We accept Debit cards. There will be a \$25 fee for returned s required by any third party members. Patients
l would like to receive email notices from P	athways To healing.
All information that is obtained from you i	by this office is protected and kept confidential in Every reasonable measure to prevent
have read, understand and agree to all the a	bove.
Signature	
	Date

Nutritional Assessment Questionnaire 1.5

	U	ate:							Date:		
Please	lis								Gender		
No.		your five major health cond	cerns in o	order of impo	rtance	:					
-				2004	N	otes:					
Controlled					_						
					_						
-					_						
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KEY:	0	Read the following question Do not consume or use	is and circle	e the number t	hat appli	les:					
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DIET			monthly		3 = 0	onsume d	r use	daily	,		
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2. 0 1	2 3	Artificial sweeteners	7. 0 1 2	3 Cigars/pipe	8	14	. 0 1		Radiation our		. 5
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		sugar	10. 0 1 2	3 Fried foods		16	. 0 1	2 3	vitamins and	minerale	
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6. 0 1	2 3	Cianalta	2. 0 1 2	3 Margarine		18	0 1	2 3	Water, tap		
-	-		13. 0 1 2	3 Milk produc	ts	20	0 1	2 3	Water, well	2 (23)	
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ileocecal valve problems (0=no, 1=yes) 38. 0 1 39. 0 1 2 3 Bone loss (reduced density on bone scan) Are you shorter than you used to be? (0=no, 1=yes) 41. 0 1 2 3 Calf, foot or toe cramps at rest Cold sores, fever blisters or herpes lesions Frequent fevers Frequent skin rashes and/or hives Herniated disc (0=no, 1=yes) Calf. 0 1 2 3 Excessively flexible joints, "double jointed" Joints pop or click Tistory of bone spurs (0=no, 1=yes) Morning stiffness Nausea with vomiting Crave chocolate Feet have a strong odor History of anemia Whites of eyes (sclera) blue tinted Hoarseness Joifficulty swallowing Lump in throat Dry mouth, eyes and/or nose Gag easily White spots on fingemails Cutte best sleet.	71	. (1	2	3	Liver and Galibladder							
73. 0 1 2 3 Greasy or otherly stools 74. 0 1 2 3 Neusses 75. 0 1 2 3 Sea, car, simplement or motion sickness 76. 0 1 1 2 3 Sea, car, simplement or motion sickness 77. 0 1 2 3 Light or dey colored stools 78. 0 1 2 3 Light or dey colored stools 79.	72		1	2	9	Stomesh shoulder blades	0		4				
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1.2 3		0	1	2	3	light or old morning sickness (0 = no. 1 = ves)			0	1			
19. 0 1 2 3 Sample of the peak of each peak of set peak peak peak of set peak peak of set peak peak of set peak peak peak peak peak peak peak peak	78.	٥	1	2	2	Drugbin the stools							History of hepatitis (O=no, 1=ye
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44. 0 1 2 3 Frequent skin rashes and/or hives 45. 0 1 Herniated disc (0=no, 1=yes) 46. 0 1 2 3 Excessively flexible joints, "double jointed" 47. 0 1 2 3 Joints pop or click. 48. 0 1 2 3 Pain or swelling in incircle. 48. 0 1 2 3 Frequent skin rashes and/or hives 48. 0 1 2 3 Herniated disc (0=no, 1=yes) 49. 0 1 2 3 Lump in throat 160. 0 1 2 3 Dry mouth, eyes and/or nose Gag easily White sept sleet.	43.	0 1	2	3	F	request forces plisters or herpes lesions	158.	0	1	2	3		
46. 0 1 2 3 Excessively flexible joints, "double jointed" 47. 0 1 2 3 Joints pop or click 48. 0 1 2 3 Pain or swelling in injects.	44.	0 1	2	3	F	GOLIANT Skin makes and	159.	0	1	2	3	-	time in three of
46. 0 1 2 3 Excessively flexible joints, "double jointed" 47. 0 1 2 3 Joints pop or click 48. 0 1 2 3 Pain or swelling in island. 48. 0 1 2 3 Pain or swelling in island.							160.	0	1	2	3	5	Dry mouth over and to
48. 0 1 2 3 Pain or swelling in leight	46.	0 1	2	3	-	KCASSIVAIV flavilale interes using a constant		•		•	•	100	7M() #96IIV
48. 0 1 2 3 Pain or swelling in leight	47.	0 1	2	3	Je	pints pop or click	162.	0	1 :	2 :	3	V	White enote on Survey !!
49. 0 1 2 8 Russide and a fullity 48.4 0 1 2 8 Russ	48.	0 1	2	3	P	Pin or swelling in tales							
Durante of tendonitie	49.	0 1	2	3	Bi	rsitis or tendonitis	164.	0	1	2 :	3	D	Decreased sense of taste or smell

165.	0 1	Essential Fatty Acids					
166.	0123	Experience pain relief with aspirin (0=no, 1=yes) Crave fatty or greasy foods	169.	٥	4	2 0	Mandant
167.	0 1 2 9	Crave latty of greasy foods	170	0		2 3	Headaches when out in the hot sun
	0 1 2 3	Low- or reduced-fat diet (0=never, 1=years ago,					
168.	0 1 2 3	2=within past year, 3=currently) Tension headaches at base of skull					Muscles easily fatigued Dry flaky skin or dandruff
		Sugar Handling	C2047Non-14-10-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1				y start of dariditall
173	0129	August Handling					
	0123	Awaken a few hours after falling asleep, hard to	180.	۸	4		At- 1 A A
			404	U	7	2 3	THE RESIDENCE OF A PARTICIPATION
174.	0 1 2 3	Crave sweets	181.	0	1	2 3	
170.	0 1 2 3	Binge or uncontrolled eating	182.	0	1	2 3	Shaku if maala dala da
	0 1 2 3	PYCHOONA ANNAMA	183.	0	1	2 3	ramily members with dishetes (O-none 4-4
177.	0 1 2 3	Crave coffee or sugar in the afternoon					
			104,	0	1	2 3	Fraguent thiret
178.	0123	Fatigue that is relieved by eating	185.	0	1	2 3	Frequent urination
Sect	tion 8 —	Vitamin Need					
186.	0123	Muscles become easily fatigued	200				-
	0 1 2 3	reel exhausted or sore after moderate avenue	200.	0	1	2 3	Can hear heart best on nillow at night
			201.	0	1	2 3	VVIDIE OROV OF IMPA IARV SA SAIR-
189.	0 1 2 3	OSS of muscle tone hands	202.	0	1	2 3	
190.	0 1 2 3	Enlarged heart or congestive heart failure	203.	0	1	2 3	Restless leg syndrome
			AUT.	U	7	23	Lifacks at corner of manch to
192.	0 1 2 3	Ringing in the ears (Tinnitus)		•			CINCING SKIP GOODLA ALASE -
180.	0 7 2 3	NUMBRIES tingling or linking in the					
			207.	0	1	2 3	MSG sensitivity
195.	0123	Fear of impending doom	208.	0	1 :	2 3	Wake up without remembering dreams
190.	0123	Worrier, apprehensive anvious					
	0123	Nervous or solitated	AIU.	u		23	STORE LIGHT of might imitate
188.	0 1 2 3	Feelings of insecurity				2 3	NOSA NIGORO SNAJAY tomal to be a constant to the constant to t
199.	0123	Heart races	212.	0	1 :	2 3	Bleeding gums especially when brushing teeth
Sect	ion 9 -	Adrenal	-		***********		-
213.	0 1 2 3	Tend to be a "night person"					7
214.	0 1 2 3	Difficulty falling asleep	226.	0	1 :	2 3	Arthritic tendencies
215.	0 1 2 3	Slow starter in the morning	227.	0	1 :	2 3	Crave salty foods
216.	0 1 2 3	Tend to be keyed up, trouble calming down	228.	0	1 2	2 3	Salt foods before testing
			448.	0	1 1	2 3	Perenire early
LIQ.	0 1 2 3	rieadache atter evercicing	230.	0	1 :	2 3	Chronic fatigue or got drawers as
219.	0 1 2 3	Feeling wired or jittery after drinking coffee		v		. 0	Alterrioon vawning
			232.	0	1 2	23	Afternoon headacha
Z1.	0 1 2 3	Calm on the outelds troubled and the	433.	0	1 2	23	Asthma, wheezing or difficulty because
		Decome dizzy when standing up and and.		•			I BUILDENCY TO SPICE SPICE OF WALLS
124. 125	0 1 2 3	PHICHILY MEMBER TO MARINI MATINA CAMPANIA		-			TOTAL TO THE CONTROL OF THE CONTROL
225.		rain after manipulative correction	238.	0	1 :	2 3	Allergies and/or hives Weakness, dizziness
		Pitultary					dictiloss
239.	0 1	Height over 6' 6" (0=no, 1=yes)	245.	0			Helmha under di den de
240.	0 1	Early sexual development (before age 10) (0=00	246.				Height under 4' 10" (0=no, 1=yes)
144		1-yes)			7 2	2 3	
41.	0 1 2 3	Increased libido	247.	0	1 2	3	Excessive thirst
242.	0 1 2 3	Splitting type headache	440.	0	1 2	3	Weight gain around hips or waist
243.	0 1 2 3	Memory falling	440.	U	7 2	2 3	menstrual disorders
244.	0 1	Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)	250.	0	1		Delayed sexual development (after age 13) (0=no, 1=yes)
		(U-11U, 1=VES)	O. W. 4		VALUE OF		Tendency to ulcers or colitis

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		Thyroid						48
	0 1 2 3	Sensitive/allergic to iodine	260.	0 .	1 2	2 3	Mentally sluggish, reduced initiative	
53.	0 1 2 3	Difficulty gaining weight, even with large	261.			3	Easily fatigued, sleepy during the day	
54.	0 1 2 3	appetite	262.	0 .	1 2	2 3	Sensitive to cold, poor circulation (cold hands	
	0123	Nervous, emotional, can't work under pressure					and feet)	
		Inward trembling	263.	0	1 2	2 3		
		Flush easily	264.	0	1 2	2 3	Excessive hair loss and/or coarse hair	
	0 1 2 3	Fast pulse at rest	265.	0	1 2	2 3	Morning headaches, wear off during the day	
58.	0 1 2 3	Intolerance to high temperatures	266.	0	1 2	2 3	Loss of lateral 1/3 of eyebrow	
259.	0 1 2 3	Difficulty losing weight	267.	0	1 2	2 3	Seasonal sadness	
Sect	ion 12 -	Men Only						27
268.	0 1 2 3	Prostate problems	272.	0	1 :	2 3	Waking to urinate at night	0.575.0
269.	0 1 2 3	Difficulty with urination, dribbling	273.			2 3		
270.	0 1 2 3	Difficult to start and stop urine stream	274.				Pain on inside of legs or heels	
271.	0 1 2 3	Pain or burning with urination	275.	0	1 2	2 3	Feeling of incomplete bowel evacuation	
			276.			2 3		
Sect	ion 13 -	- Women Only						60
	0 1 2 3	Depression during periods	287.	0	1	2 3	Breast fibroids, benign masses	
	0 1 2 3	Mood swings associated with periods (PMS)	288.			2 3		
279.	0 1 2 3	Crave chocolate around periods	289.			2 3		
280.	0 1 2 3	Breast tenderness associated with cycle	290.				Vaginal dryness	
281.	0 1 2 3	Excessive menstrual flow	291.			2 3		
282.	0 1 2 3	Scanty blood flow during periods	292.	0	1	2 3		
283.		Occasional skipped periods	293.	0	1	2 3	Excess facial or body hair	
284.		Variations in menstrual cycles	294.	0	1	2 3		
285.		Endometriosis	295.	0	1	2 3	Night sweats (in menopausal females)	
286.	0 1 2 3	Uterine fibroids	296.	0	1	2 3		
Sect	ion 14 -	- Cardiovascular						30
297.	0 1 2 3	Aware of heavy and/or irregular breathing	302.	0	1	2 3	Ankles swell, especially at end of day	
	0 1 2 3	Discomfort at high altitudes	303.				Cough at night	
299.	0 1 2 3	"Air hunger" or sigh frequently	304.			2 3	Blush or face turns red for no reason	
		Compelled to open windows in a closed room	305.	0.00	19 1	2 3		
	0 1 2 3		500.	٠		2 3	into right arm, worse with exertion	
			306.	0	1	2 3	Muscle cramps with exertion	
Sect	ion 15	- Kidney and Bladder						1:
307.	0 1 2 3	Pain in mid-back region	310.	0	1	2 3	Cloudy, bloody or darkened urine	
308.	0 1 2 3	Puffy around the eyes, dark circles under eyes	311.	1		V.C.	Urine has a strong odor	
309.		History of kidney stones (0=no, 1=yes)						
Sect	tion 16	- Immune system						3
312.	0 1 2 3		317.	0	1	2 3	Never get sick (0 = sick only 1 or 2 times in las	st
313.	0 1 2 3	Catch colds at the beginning of winter					2 years, 1 = not sick in last 2 years, 2 = not	
314.	0 1 2 3	Mucus producing cough					sick in last 4 years, 3 = not sick in last 7 years	s)
315.	0 1 2 3	Frequent colds or flu (0=1 or less per year, 1=2	318.	0	1	2 3		
		to 3 times per year, 2=4 to 5 times per year, 3=6	319.	0	1	2 3		
		or more times per year)	320.			2 3		
316.	0 1 2 3		321.			2 3		
		kidney, etc.) (0=1 or less per year, 1=2 to 3					Shingles, Chronic Fatigue Syndrome, Hepatiti	tis
		times per year, 2=4 to 5 times per year, 3=6 or					or other chronic viral condition (0 = no, 1 = ye	
								-0
		more times per year)					in the past, 2 = currently mild condition, 3 =	