Patient Information

Atlanta Yajima Chiropractic   5000 Winters Chapel Rd. Ste 1, Dunwoody, GA 30360

Today's Date:	Date of Birth:
Full Name:	Marital Status: Single/Married/Divorced/Widow(er)
Address:	Employer: Full Time/ Part Time/ Retired
City:	Occupation:
State: ZIP:	Work Phone:
Home Phone:	Spouse's name:
Cell Phone:	Spouse's Employer:
Email:	Referred By?
Gender: Male / Female	What brings you in today?

Fees For Services Rendered

_______ initials **Fees are payable when service is rendered unless other arrangements have been made in advance.** Insurance co-payments are due at time of service. Ancillary services will be an additional fee. Fees are subject to change without notice. Return checks are subject to a $25 fee.

Overdue Accounts

_______ initials I understand that if my account is overdue by 60 days Atlanta Yajima Chiropractic will send this account to a collection agency or attorney for collection. Any/All fees including collection percentages will be added to the unpaid balance and be the sole responsibility of the undersigned. Collection fees, Attorney fees and court costs will be the sole responsibility of the undersigned. If you do not agree to the collection policy then it will be necessary to collect fees prior to services rendered.

Acknowledgement of Notice of Privacy Practices

_______ initials I hereby acknowledge that I have received the Notice of Privacy Practices statement

_______ initials I understand this office utilizes Both open and private procedures. This means multiple patients may receive care in one room at the same time. In this situation, other patients may observe your care in this office. If this presents a major concern to you, please notify your doctor and we will do our best to accommodate your concerns

Consent for Chiropractic Care

_______ initials I authorize Atlanta Yajima Chiropractic to analyze for Subluxation and administer care that is deemed necessary.

_______ initials If X-rays are deemed necessary for complete analysis of my health challenge, I authorize Atlanta Yajima Chiropractic to perform such radiographic examinations.

_______ initials I authorize Atlanta Yajima Chiropractic to release any information or office records to my insurance company or lawyer.

_______ initials I authorize the release and the payment of health benefits to Atlanta Yajima Chiropractic and the respective doctor. This is to serve as a long term authorization.

Patient or Legal Guardian Signature ____ Date ________________

Print Name ____

Atlanta Yajima Chiropractic
5000 Winters Chapel Rd. Ste 1
Dunwoody, GA 30360

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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 or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

____ ____________________________________

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

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 cycle: ____

____ _______________________

Signature Date

Only for Insurance Patients

Primary Insurance Holder's Name	
Primary Insurance Holder's S.S.#	
Primary Insurance Holder's Date of Birth	
Relationship to Insured	Self / Spouse / Children / Other

Cancellation and Rescheduling Policy

After reviewing the information, please sign below to show that you consent to the policy.

We desire to serve you at your appointment time in a timely matter. In order to do so, please try your best to do the following.

If you are unable to make it to your appointment and need to reschedule, please contact the office as soon as possible.

If you are more than 10 minutes late to your appointment, we may not have enough time to complete your adjustment session. In this case, we may need to reschedule your appointment to another time.

In the case of a no-show, we will be charging the full price of your treatment. If you are a new patient, this would include the fee for an adjustment and an exam.

I, ____________________________________, consent to the above information.

Signature _____________________________________ Date_____________

Confidential Patient History

Name____Date___/___/___

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. THANK YOU!
For each symptom, ***Circle N, O, F*** *or* ***C*** *for* ***N****ever,* ***O****ccasional,* ***F****requent, or* ***C****onstant*
Rate *the pain from* ***1-10****, with 0=nothing and 10=most severe.*
Note how long *you have had this problem.*

Nerve Level	Symptom	Never	Occasional	Frequent	Constant	Severe 1-10	How long?	Any Notations
C1	Headache	N	O	F	C			
	Migraine	N	O	F	C			
	Dizziness	N	O	F	C			
	Vertigo/Poor balance	N	O	F	C			
	Ringing in the ears	N	O	F	C			
	Fatigue	N	O	F	C			
	Insomnia	N	O	F	C			
	High blood pressure	N	O	F	C			
C2	Sinus congestion	N	O	F	C			
	Sinus headache	N	O	F	C			
	Nosebleeds	N	O	F	C			
	Visual disturbances: nearsighted, farsighted, floaters	N	O	F	C			
	Difficulty concentrating	N	O	F	C			
	Earaches	N	O	F	C			
	Ear infections	N	O	F	C			
	Fullness in ears	N	O	F	C			
C3	Facial pain	N	O	F	C			
	Phantom tooth pain	N	O	F	C			
	Jaw popping/TMJ	N	O	F	C			
C4	Difficulty hearing	N	O	F	C			
	Hay fever	N	O	F	C			
C5	Laryngitis	N	O	F	C			
	Hoarseness	N	O	F	C			
	Sore throat	N	O	F	C			

Confidential Patient History

Nerve Level	Symptom	Never	Occasional	Frequent	Constant	Severe 1-10	How long?	Any Notations
C6	A.M. muscle stiffness	N	O	F	C			
	Stiff neck	N	O	F	C			
	Pain in upper arms	N	O	F	C			
	Pain in hand	N	O	F	C			
	Tonsilitis	N	O	F	C			
C7	Thyroid condition	N	O	F	C			
T1	Wheezing	N	O	F	C			
	Difficulty breathing	N	O	F	C			
	Shortness of breath	N	O	F	C			
	Numbness in arms	N	O	F	C			
	Pain in shoulder	N	O	F	C			
	Pain in elbow	N	O	F	C			
	Pain in wrist	N	O	F	C			
T2	General chest pain	N	O	F	C			
	Pain over heart	N	O	F	C			
	Heart racing	N	O	F	C			
	Heart skipping/fluttering	N	O	F	C			
T3	Bronchitis	N	O	F	C			
	Pneumonia	N	O	F	C			
T4	Gall bladder problems	N	O	F	C			
	Shingles	N	O	F	C			
T5	Low blood pressure	N	O	F	C			
T6	Heartburn	N	O	F	C			
	Difficult digestion	N	O	F	C			
	Nausea	N	O	F	C			
	Acid reflux	N	O	F	C			
T7	Ulcers	N	O	F	C			
T8	Frequent illnesses	N	O	F	C			
	Low energy/fatigue	N	O	F	C			
	Hyperactive	N	O	F	C			
	Cycles of energy/fatigue	N	O	F	C			

Confidential Patient History

Nerve Level	Symptom	Never	Occasional	Frequent	Constant	Severe 1-10	How long?	Any Notations
T9	Food allergies	N	O	F	C			
	Hives	N	O	F	C			
T10	Kidney trouble	N	O	F	C			
T11	Severe acne	N	O	F	C			
	Very dry skin	N	O	F	C			
T12	Gas pains	N	O	F	C			
	Diverticulitis	N	O	F	C			
L1	Constipation	N	O	F	C			
	Diarrhea	N	O	F	C			
	Excessive belching/gas	N	O	F	C			
	Irritable bowel syndrome	N	O	F	C			
	Colitis	N	O	F	C			
L2	Cramps	N	O	F	C			
	Varicose veins	N	O	F	C			
L3	Bladder troubles	N	O	F	C			
	Painful urination	N	O	F	C			
	Bedwetting	N	O	F	C			
	Hot flashes	N	O	F	C			
	Low back pain	N	O	F	C			
	Painful menses (women)	N	O	F	C			
	Irregular cycle (women)	N	O	F	C			
	Impotency (men)	N	O	F	C			
	Prostate trouble (men)	N	O	F	C			
L4	Sciatica	N	O	F	C			
	Buttock pain	N	O	F	C			
	Hip pain	N	O	F	C			
L5	Leg pain	N	O	F	C			
	Poor circulation/legs	N	O	F	C			
	Numb/tingling legs	N	O	F	C			
	Swollen ankles	N	O	F	C			
	Numb/tingling feet	N	O	F	C			
	Pain in feet	N	O	F	C			
	Cold feet	N	O	F	C			
S1	Hemorrhoids	N	O	F	C			

Confidential Patient History

Please write a **"C"** next any of the following conditions you **Currently** have

Please write a **"P"** next any of the following conditions you've had in the **Past**

Alcoholism___	Drug Addiction___	Mumps___
Anemia___	Emphysema___	Pleurisy___
Appendicitis___	Epilepsy___	Pneumonia___
Arteriosclerosis___	Fever Blisters___	Polio___
Arthritis___	Goiter___	Rheumatic Fever___
Asthma___	Gout___	Scarlet Fever___
Bursitis___	Heart Disease___	Stroke___
Cancer___	Influenza___	Tuberculosis___
Chorea___	Malaria___	Typhoid Fever___
Cold Sores___	Measles___	Ulcers___
Diabetes___	Miscarriage___	Venereal Disease___
Diphtheria___	Multiple Sclerosis___	Whooping Cough___

If you have had none of the above symptoms please circle: NONE OF THE ABOVE

All recent accidents or injuries:

	Date:	Describe:
1)		
2)		
3)		
4)		
5)		
6)		

All past accidents or injuries:

	Date:	Describe:
1)		
2)		
3)		
4)		
5)		
6)		

Confidential Patient History

All hospitalizations, surgeries, or broken bones:

Date: Describe:

1) ____________________ ____
2) ____________________ ____
3) ____________________ ____
4) ____________________ ____
5) ____________________ ____
6) ____________________ ____

List all <u>prescription</u> medications you have taken in the last month:

Name Reason for Taking: Dosage: How long:

1) ____
2) ____
3) ____
4) ____
5) ____
6) ____

List all <u>over the counter</u> medications you have taken in the last month:

Name Reason for Taking: Dosage: How long:

1) ____
2) ____
3) ____
4) ____
5) ____
6) ____

List any health problems that were not previously mentioned:

1) ____
2) ____
3) ____

Other Doctors seen for these health problems:

Chiropractors____

Medical Doctors ____

Other____

The statements made on this form are accurate to the best of my recollection.

___ ____________________ ________________

Signature Date