PATIENT HISTORY

Date of Birth: Age: SSN:

Last Name: First Name:

Address:

City: State: ZIP:

Phone (H): (Cell): Email:

Spouse's Name: # of Children:

Your Occupation: Employer:

Do You Have Insurance?: YES NO Name of Insurance:

Have You Ever Been To Another Doctor For This Problem?: YES NO

Who Referred You To This Office?

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT: Date First Appeared:

How Did It Begin? Gradually Sudden Progressive Over Time

What Makes Symptoms Worse?:

What Relives Symptoms?:

Type of Pain: Sharp Dull Ache Burn Throb

Does The Pain Radiate Into Your: Arm Leg Does Not Radiate

How Often Do You Experience These Symptoms? : 100% 75% 50% 25%

Pain Intensity: Please draw a line on the scale describing the intensity of your pain

NO PAIN **UNBEARABLE PAIN**

OTHER COMPLAINT: Date First Appeared:

How Did It Begin? Gradually Sudden Progressive Over Time

What Makes Symptoms Worse?:

What Relives Symptoms?:

Type of Pain: Sharp Dull Ache Burn Throb

Does The Pain Radiate Into Your: Arm Leg Does Not Radiate

How Often Do You Experience These Symptoms? : 100% 75% 50% 25%

Pain Intensity: Please draw a line on the scale describing the intensity of your pain

NO PAIN **UNBEARABLE PAIN**

PATIENT'S SIGNATURE: Date:

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of Treating Physician:_____ Date of Treatment:_____

Type of Treatment or Drugs Prescribed:_____

Name of Treating Physician:_____ Date of Treatment:_____

Type of Treatment or Drugs Prescribed:_____

Please list all past surgeries:

Type: _____ When:_____ Doctor:_____

Type: _____ When:_____ Doctor:_____

Type: _____ When:_____ Doctor:_____

Type: _____ When:_____ Doctor:_____

Please list all previous accidents and falls:

What:_____ When:_____

What:_____ When:_____

What:_____ When:_____

What:_____ When:_____

Please list any medications or vitamins you are currently taking:

_____

_____

_____

DOCTOR'S NOTES

_____

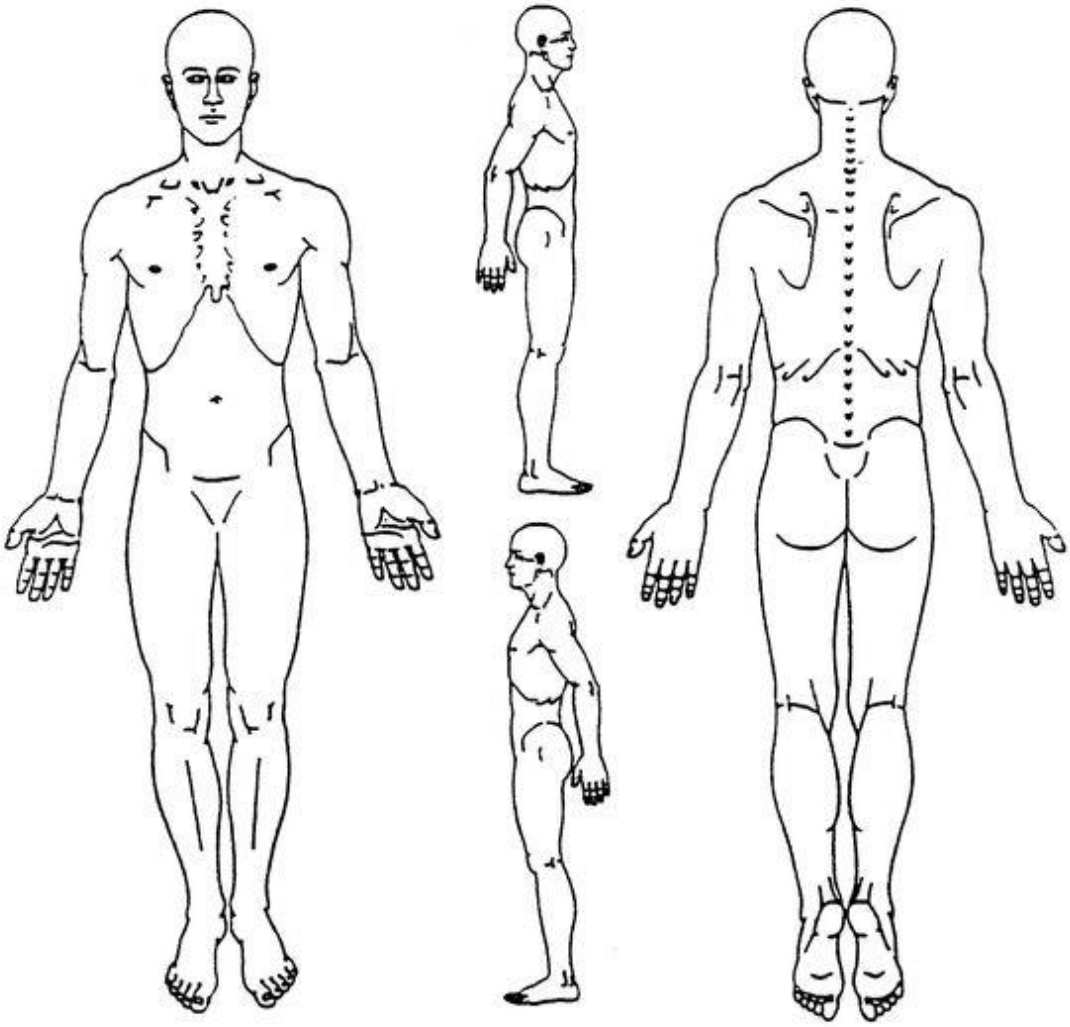
_____

_____

_____

PATIENT'S SIGNATURE:_____ Date:_____

PATIENT HISTORY: PAIN LOCATION



Please mark off the areas of your complaint in the diagram above. 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'S SIGNATURE:_____ Date:_____

Bankhead Chiropractic
915 W Hwy 78
Villa Rica, GA 30180

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his hands or a mechanical device in order to move your joints. You may feel a 'click' or a 'pop' such as the noise when a knuckle is 'cracked' and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, and dislocations of joint or injury to intervertebral disc, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after their first few days of treatment. The ancillary procedures could produce skin irritations, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as 'rare', about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reactions due to ancillary procedures is also considered 'rare'.

Other treatment options which could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable diseases in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia as well as an extended convalescent period in a signification number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probably that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Usual Risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

PATIENT SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____

WITNESS SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Phillip S. Butch DC, LLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to Phillip S. Butch DC, LLC will be credited to my account by receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable. A service charge will be added after 30 days unless predetermined arrangements have been made.

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, Georgia Department of Insurance, or adjusted in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I offer limited Power of Attorney in the even a payment is made to a doctor's office on my half and requires my signature. You may endorse and apply payment to my account.
3. In the even any insurance company obligated by contractual agreement to make payments to me or to ou for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name/s of which is believe to be correctly set forth under pertinent date below) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromised, settle, or otherwise resolved said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether if be all or part of what is due, I personally owe you. In the event that the account goes 180 days past due interest will be added. If an outside collection company is used, the collection fees will be added the balance of the account.
4. I HEREBY AUTHORIZE DR. PHILLIP S. BUTCH TO CARE FOR MY CONDITION AS HE DEEMS APPROPRIATE. IT IS UNDERSTOOD AND AGREED THAT THE AMOUNT PAID FOR X-RAYS IS FOR EXAMINATION ONLY, AND THE X-RAY NEGATIVES WILL REMAIN THE PROPERTY OF THE OFFICE, BEING ON FILE WHERE THEY MAY BE SEEN AT ANY TIME WHILE A PATIENT OF THIS OFFICE. THE DOCTOR'S OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PRE-EXISITING MEDICALLY DIAGNOSED CONDITIONS. I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.
5. This authorization and assignment shall be valid and effective for all charges and fees hereafter incurred unless retracted and revoked by me in writing.

DATE:_____ **SIGNED:** _____

WITNESS:_____

PREGNANCY FORM

I verify that my last menstrual period was _____ and that I am not pregnant at this time. The doctor and staff at Phillip S. Butch DC, LLC have been informed of my condition and are not responsible for my future condition as a result of diagnostics or chiropractic treatments completed on_____.