WELCOME

Please check with our staff if you have any questions

Name (Last, First, MI) _____ Mr. Mrs. Ms. Dr. Sr. Jr.

I prefer to be called _____ Male Female

Birthdate _____/_____/_____ Age_____ Single Married Separated Divorced Widowed

Address _____City _____ State _____ Zip_____

Email:_____

Home Phone _____ Cell _____

For Appointment Reminder Calls and Emergency Cancellation Calls: Contact Phone #_____

Employer: _____Work # _____ Occupation _____

Employer's Address: _____ City, _____State_____ Zip _____

Other Family Members seen by us: _____

How did you hear about us: _____

Emergency Contact: _____ Phone _____

Spouse's Name: _____ Birthdate _____/____/_____

Employer _____ Work Phone _____

Employer's Address _____City, State, Zip _____

Name of Insurance Company: _____

Name of Policy Holder:_____

(Person who has the insurance through work)

Policy Holder's Date of Birth _____/_____/_____

I affirm that the information I have given is correct to the best of my knowledge. I agree to inform this office of any changes in my medical status. My signature affirms I have been given a copy of, have read, and/or understand the office policy for Campbell Chiropractic

Signature _____Date_____

Campbell Chiropractic

802 Dacula Rd. Ste. 202 Dacula GA 30019

770-236-9355

Thank you for choosing Campbell Chiropractic! It is our desire to help you achieve and maintain the healthiest lifestyle possible. Please feel free to ask us about any and all issues concerning your care.

Our office is open: Monday, Tuesday & Thursday 9-1, 3-6. Fridays 9-1. Saturdays by appointment only. Closed on Wednesday & Sunday.

Our initial office visit involves a thorough head to toe exam. The doctor will evaluate you on chiropractic, orthopedic and neurological levels. We do take x-rays in this office if needed. Please bring with you any recently taken x-rays for the doctor to review. After your exam, the doctor will explain what you need, and how chiropractic care can benefit you. Your first adjustment will be given on the first visit unless your condition indicates otherwise. Doctor Raylene uses a “hands-on” approach and will explain every step to you during your treatment. Other modalities are available for your care if needed. Dr. Raylene is also versed in many different techniques to specifically treat your condition.

A financial policy is a necessary part of any business. It is our desire to operate as efficiently as possible. Our fees are competitive and we offer insurance filing of claims.

For accounts without insurance, we expect payment in full at the time of treatment.

If you have insurance, all deductibles and co-payment amounts are due at each visit. If your insurance cannot be verified prior to your visit, we require full payment on your first visit. We are happy to help you with your insurance claims. However, we ask that you remember that you are ultimately responsible for understanding your own policy. We will call to verify your insurance coverage and co-pay amounts as a courtesy to you, but we cannot be responsible for the information given to us by your insurance provider. Please refer to your insurance booklet to verify your coverage limits. Knowing the specifics of your policy will help you make informed health care decisions. Please be aware that if a service is denied we are obligated to bill you for that service. All payments are due upon request.

Any amount not paid to us within 60 days by an insurance company will automatically be billed to you for prompt payment. If an insurance payment is received after you have paid, we will gladly apply it toward any additional treatment or refund your money if your account has a zero balance. A finance charge and late fee will be added monthly once the account becomes past due.

We accept cash, personal checks, Visa, MasterCard, and American Express. There will be a $25 charge for any check returned for insufficient funds.

Please let us know if you have any concerns, questions, or comments and our staff will gladly assist you.

Campbell Chiropractic & Massage

FAMILY HISTORY

YOUR NAME _____

Physician's Name: _____ Phone # _____ Date of last visit _____

Address: _____ City/State _____ Zip _____

Please list any medications you are currently taking: _____
_____
_

Please list any family (genetic) health problems: (like cancer, diabetes and heart disease)

Mother _____ Father _____

Siblings _____ Grandparents _____

MEDICAL HISTORY

Your current physical health is: _Good _Fair _Poor

Have you been to a Chiropractor before? _Yes _No
If yes, when and for what purpose _____

Name of Chiropractor _____

Do you take vitamins or minerals? _Yes _No
If so, please list: _____

Do you think you need to take vitamins/minerals? _Yes _No

Are you taking any laxatives and/ or sleeping pills? _Yes _No
If so, how many, how often? _____

Are you under a lot of stress on a daily basis? _Yes _No

How long has it been since you really felt good? _____

During the day I (please circle) sit, stand, walk, desk work, phone work, computer work, drive, mechanical work, heavy lifting.

Do you read in bed? _Yes _No

Is your mattress comfortable? _Yes _No

Are you right or left-handed? _Right __ Left

Do you smoke or use tobacco in any other form? _Yes _No
Have you ever been involved in a bicycle, bus, train, motorcycle or car accident? _Yes _No
Please explain: _____
_____
_____

Were you ever knocked unconscious? _Yes _No

Have you broken any bones? _Yes _No
Please explain _____
_____

Have you had any impacts, falls or jolts that you feel may have injured you? _Yes _No
Please explain: _____
_____

Have you had any surgeries? _Yes _No
Please list: _____
_____
_____

FOR WOMEN:

Are you taking birth control pills? __ Yes __ No
Age Periods stopped and why _____
_____

Are you pregnant? __ Unsure __ Yes __ No
Are you nursing? __ Yes __ No

DO YOU HAVE OR HAVE YOU EXPERIENCED THE FOLLOWING? PLEASE CHECK ALL THAT APPLY

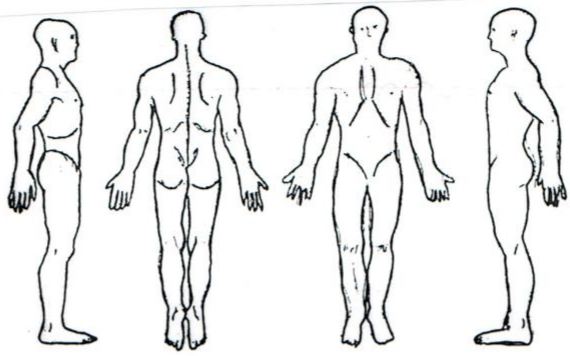
_Abnormal Bleeding
_Alcohol Abuse
_Arthritis
_Allergies
_Anemia
_Artificial Bones
_Artificial Joints
_Asthma
_Artificial Valves
_Blood Transfusion
_ Cancer
_Chemotherapy
_Chicken Pox
_Colitis
_Congenital Heart Defect
_Depression
_Diabetes
_Difficulty Breathing
_Drug Abuse
_Emphysema
_Epilepsy
_Fainting Spells
_Fatigue
_Fever Blisters
_Glaucoma
_Gout
_Hay Fever
_Headaches
_Heart Disease/Problems
_Hemophilia
_Hepatitis
_Herpes
_High Blood Pressure
_HIV+/AIDS
_Hospitalized
_Kidney Problems
_Kidney Stones
_Leukemia
_Liver Disease/Problems
_Low Blood Pressure
_Lupus
_Migraine
_Mitral Valve Prolapse
_Obesity
_Pacemaker
_Persistent Cough
_Psychiatric Problems
_Radiation Treatment
_Rheumatic Fever
_Rheumatism
_Scarlet Fever
_Sciatica
_Scoliosis
_Seizures
_Shingles
_Sickle Cell Disease
_Sinus Problems
_Stroke
_Suicidal Thoughts
_Thyroid Problems
_ Tonsillitis
_Tuberculosis (TB)
_Ulcers
_Venereal Disease
_Other _____
_____
_____
_____
_____

EXPLANATION OF CONDITION

Patient Name _____ **Date:** _____

Please mark areas of injury or discomfort using the key below.

KEY:
Numbness - - - -
Pins & Needles ooooo
Burning ^^^^
Aching xxxxx
Stabbing 0000



Your Chief Complaint is _____

_____

When did your problem begin? _____

Describe how your condition occurred in detail: _____

_____

Rate your pain: (Circle one) 0 No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Are you worse in the morning? ___Yes ___No

Are you worse at the end of the day? ___Yes ___No

What position(s) aggravates your condition (please circle all that apply)

Sitting **Standing** **Driving** **Walking** **Sleeping** **Sit to Stand**

Did you do anything to relieve this problem? ___Yes ___No

If yes, please explain: _____

Did you use ice? ___Yes ___No **Did you use heat?** ___Yes ___No

Have you seen any other doctors for this condition? ___Yes ___No

If so, who? _____

Have you ever experienced this condition in the past? ___Yes ___No

If yes, explain_____

How much water do you drink each day? Glasses/Bottles _____