WELCOME

Chart #:_____

Patient Information

Name: _____ _____ _____
Last First MI

Mailing Address: _____ City_____ ST._____ ZIP_____

Phone# (H) _____ (M) _____

Date of Birth:_____ Sex: ☐ Male ☐ Female SS#:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Employer:_____ Phone:_____

Email _____Can we leave a voicemail/message? Yes/No

Who referred you to our practice?_____ ☐ Insurance Book ☐Google

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐Other_____

Has it been reported? ☐ Yes ☐ No If yes to whom?_____

Financial Information

Do you have health insurance? ☐ Yes ☐ No Name of Carrier:_____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier:_____

Name of person whose is the policy holder of this insurance:_____ SS#: _____

Relationship to patient (if other than self):_____ DOB: _____ Phone:_____

ID #_____ Group #_____member services phone number _____

We can not file your insurance if this section is left uncompleted and the bill will be sent to you.

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment, Consent of Care and Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

PATIENT SIGNATURE (X)_____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

HIPAA

I was given the opportunity to receive and review the office's Patient Notice of Privacy Practices policy.

PATIENT SIGNATURE (X)_____ DATE_____

HEALTH HISTORY

Who is your primary care physician (doctor and/or practice)? _____

Please check to indicate if you are currently experiencing any of the following conditions:

Neck Pain/Stiffness
Back Pain/Stiffness

- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Other
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsilitis
- ❑ Tumors/Growths
- ❑ Typhoid Fever

Are you currently under medical care? ☐ Yes ☐ No If yes, explain_____

Please list any medications you are currently taking:_____

_____

Please list any surgeries and/or hospitalizations you have had (type & date):_____

_____

_____

Please list any allergies:_____

Please list any supplements you are currently taking (vitamins/herbs/minerals):_____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- ❑ Heart Disease_____
- ❑ Cancer_____
- ❑ Diabetes_____
- ❑ Arthritis_____
- ❑ Other_____

Do you exercise? ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

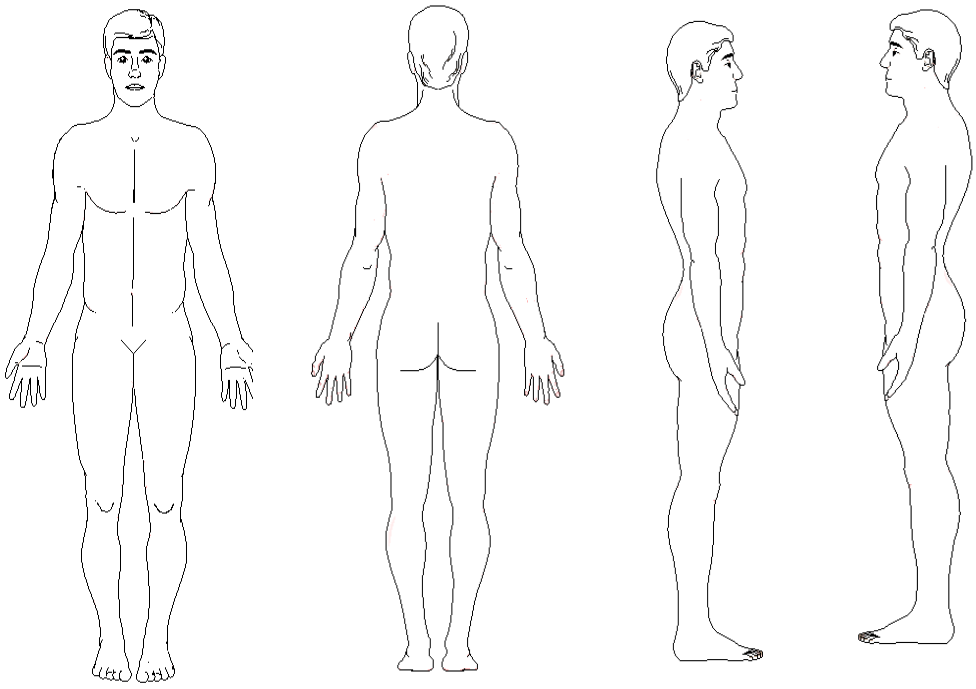
What is your daily/weekly intake of the following?

Caffeine_____ cups/day Alcohol_____ drinks/week Cigarettes _____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

* PLEASE USE THE LETTER (S) BELOW TO MARK THE DRAWING(S) WITH THE LOCATION AND TYPE OF SENSATIONS YOU ARE EXPERIENCING. PLEASE MARK ALL SYMPTOMS THOROUGHLY SO WE CAN BETTER ASSIST YOU

KEY:
P = Pain
D = Dull
N = Numb
B = Burning
T = Tingling
SH= Shooting
TH= Throbbing
O = Other
M = Muscle Spasm



* PLEASE INDICATE THE SEVERITY OF YOUR CONDITION ON A SCALE OF **0-10**

(0 being no pain, 10 being the worst possible pain) 1._____ currently 2._____ at it's worst

When did you first notice the symptoms?_____

Did anything cause the pain/symptoms?_____

Is the pain: ☐ Constant OR ☐ intermittent (Come and Go)

Is it getting progressively worse? ☐ No ☐ Yes

Type of Pain? ☐ Tight ☐ Stiff ☐ Ache ☐ Sharp ☐ Shooting
☐ Throbbing ☐ Burning ☐ Dull ☐ Numb ☐ Tingling ☐ Other

Does anything make it worse?_____

Does anything make it better?_____

Does it radiate? ☐ No ☐ Yes ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Do you experience the pain at a particular time of day?_____

Do you experience night pain? ☐ No ☐ Yes, explain_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational Activities

What activities do you enjoy, but do poorly, or not all because of the pain? _____

Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What have you done to treat the pain before today?_____

PATIENT SIGNATURE (X)_____ DATE_____

PARENT/GUARDIAN SIGNATURE (X)_____DATE_____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of hand grip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
    Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment: _____
15. Do you suffer from ringing in your ears? NO YES
    Comment: _____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGMENT FORM

CHRIS BROOKS, P.C

I, _____have read a copy and understand the Notice of Privacy Practices of CHRIS BROOKS, P.C. This notice will be effective until I leave the above practice.

_____ _____

Signature of Patient or **Date**

Parent or Legal Guardian

_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Patient Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to signature

Communication barriers prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgment

Other (please specify)

_____

_____

_____

Patient Consent for Use and Disclosure
of Protected Health Information
CHRIS BROOKS, P.C.

I hereby give my consent for CHRIS BROOKS, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO)

CHRIS BROOKS, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHRIS BROOKS, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CHRIS BROOKS, P.C. Christopher Brooks at 2821 S. Cobb Dr. Smyrna, GA 30080.

With this consent, CHRIS BROOKS, P.C. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist to practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, CHRIS BROOKS, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they marked Personal and Confidential.

With this consent, CHRIS BROOKS, P.C. may e-mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that CHRIS BROOKS, P.C. restrict how it uses or discloses PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CHRIS BROOKS, P.C.'s use and disclosure of my PHI to carry out TPO.
With this consent, I hereby give CHRIS BROOKS, P.C. specific permission to post my name on the referral board in acknowledgment for the referral of new patients.

With this consent, CHRIS BROOKS, P.C. may post and label photographs of myself for a patient bulletin board.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, CHRIS BROOKS, P.C. may decline to provide treatment to me.

_____

Signature of Patient

_____ _____

Patient's Name **Date**

_____

Printed Name of Patient or Legal Guardian