Art of Life
CHIROPRACTIC ~ WELLNESS

CONFIDENTIAL HEALTH INFORMATION

Dr. Eric A Shearer
Peachtree City
Georgia 30269
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Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes

When?

If so, whom?

Patient Number (office use only)

Whom may we thank for referring you?

Age

Gender
○ Male ○ Female

Birth Date (MM/DD/YYYY)

Race
○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American
○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White
○ Decline to answer

Ethnicity
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to specify

Your Last Name

Your First Name

Your Middle Name (or Initial)

Smoking Status (age 13 and over)
○ Never A Smoker ○ Former Smoker
○ Current Every Day Smoker ○ Current Some Day Smoker
○ Heavy Smoker ○ Light Smoker

Address

City

State/Province

ZIP/Postal Code

Marital Status ○ Married
○ Single ○ Divorced
○ Widowed ○ Separated

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Work Phone

May we contact you at work?
○ Yes ○ No

Primary Care Provider's Name

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

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Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: ______________________

And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other __________

○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _______

Onset (When did you first notice your current symptoms?) ______________

Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Acupuncture
○ Over-the-counter drugs ○ Chiropractic
○ Homeopathic remedies ○ Massage
○ Physical therapy ○ Ice
○ Surgery ○ Heat
○ Other ______________

Secondary Complaint
The secondary symptom that prompted me to seek care today is: ______________________

And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other __________

○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _______

Onset (When did you first notice your current symptoms?) ______________

Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Acupuncture
○ Over-the-counter drugs ○ Chiropractic
○ Homeopathic remedies ○ Massage
○ Physical therapy ○ Ice
○ Surgery ○ Heat
○ Other ______________

Additional Complaint
The additional symptom that prompted me to seek care today is: ______________________

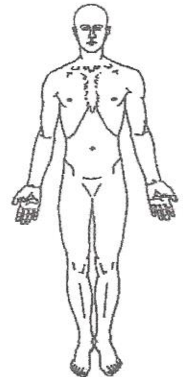
And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other __________

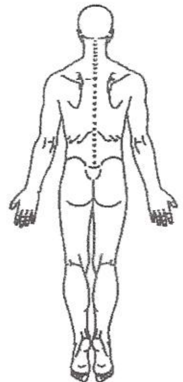
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _______

Onset (When did you first notice your current symptoms?) ______________

Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Acupuncture
○ Over-the-counter drugs ○ Chiropractic
○ Homeopathic remedies ○ Massage
○ Physical therapy ○ Ice
○ Surgery ○ Heat
○ Other ______________

Location
(Where does it hurt?) Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past





1. What else should Dr. Shearer know about your current condition? ______________________

2. How does your current condition interfere with your:

Work or career: ______________________

Recreational activities: ______________________

Household responsibilities: ______________________

Personal relationships: ______________________

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	NONE ○
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	Initials ____

b. Neurological

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness	NONE ○ Initials ____

c. Cardiovascular

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising	NONE ○ Initials ____

d. Respiratory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	NONE ○ Initials ____

e. Digestive

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	NONE ○ Initials ____

f. Sensory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	NONE ○ Initials ____

g. Skin

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	NONE ○ Initials ____

____
Patient Initials

____
Doctor's Initials

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h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	NONE ○ Initials ____

____
Patient Initials

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ____________
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: ____________

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____________
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____________
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____________

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): ____________

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Shearer about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

10. Are there any other hereditary health issues that you know about? ____________

11. Social History

Tell Dr. Shearer about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?____________
Coffee use	○ Daily	○ Weekly	How much?____________
Tobacco use	○ Daily	○ Weekly	How much?____________
Exercising	○ Daily	○ Weekly	How much?____________
Pain relievers	○ Daily	○ Weekly	How much?____________
Soft drinks	○ Daily	○ Weekly	How much?____________
Water intake	○ Daily	○ Weekly	How much?____________

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Hobbies: ____________

____
Doctor's Initials

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12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? ____________________ **14. How much sleep do you average per night?** ______ **Hours**

15. What is the type and approximate age of your mattress and pillow? ________ **16. What is your preferred sleeping position?** ____________

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? ____________________

19. In addition to the main reason for your visit today, what additional health goals do you have? ____________________

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** ____________

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient (or Guardian's) signature ____________________ Date (MM/DD/YYYY) ____________

Patient Initials

Consultation Notes

Doctor's Initials

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Art of Life Chiropractic and Wellness

Signature Form

Consent to Treat: I consent to treatment rendered by the physician and his directed medical staff at the Art of Life Chiropractic and Wellness.

With my consent, Art of Life Chiropractic and Wellness may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

Release of Medical Records: I further authorize Art of Life Chiropractic and Wellness to release to me any information that I may request from my medical record. I authorize the release of my medical information to process insurance claims all in accordance with the guidelines set forth in the practice's Notice of Privacy Practices (available for my review upon request). Art of Life Chiropractic and Wellness reserves the right to revise it's Notice of Privacy Practices at any time.

Financial Responsibility: I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED. This responsibility applies to co-payment, deductibles, Co-insurance amounts, full payment if uninsured and payment for procedures that are not covered by my insurance carrier(s). I will be responsible for payment for my visit today for nutritional or wellness visits.

Check Policy: If your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $30.00.

Your insurance is a contract between you and your insurance company. Coverage benefits will vary based on your personal policy.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our **Notice of Privacy Practices.**

Nutritional: According to the Federal Food Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean "Articles intended for use in the Diagnosis, Cure, Mitigation and Treatment or Prevention of disease"

Vitamins and natural supplements are not drugs. Although natural supplements, enzymes, minerals, Amino Acids and Herbs may have an effect on any disease process or symptom, this does not mean that it can be misrepresented or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and /or therapy for any disease or particular bodily symptom.

Nutritional counseling, supplement recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the body. Nutritional advice and nutritional intake may also enhance the stabilization of Chiropractic / spinal care and treatment.

Signature: ______________________________ Date: ____________________

Print Name: ____