

CONFIDENTIAL CASE HISTORY

Date _____ Case# _____

Name _____
(First) (Middle) (Last) (Nickname- Name you go by)

Home Address _____ Birthdate ____/____/____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____ Cell _____ email _____

Sex: M F Marital Status: S M D W Social Security Number _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Name of Spouse (or Responsible Party if Patient is a dependent Child) _____

Spouse's (Responsible Party's) Birth date ____/____/____ Social Security Number _____

Spouse's Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Referred by _____ Past Chiropractic Care Yes No When? _____

Doctor's Name _____ Results _____

Chief Complaint 1. _____
 2. _____
 3. _____

Insurance Companies _____

Are your present injuries due to an injury? No Yes On the job Auto Accident Personal Injury Other
 Have you made a report of your accident? No Yes To employer Auto Carrier Other _____
 Has the accident been reported? No Yes Workers Comp. Auto Carrier Other _____
 Are you now or have you ever been disabled? (Service or Work)? No Yes When _____
 Have you retained an attorney? No Yes Name & Address _____

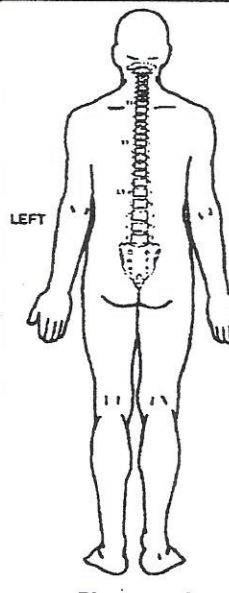
PLEASE GIVE MOST CURRENT DATE

Spinal Exam _____
 MRI Exam _____
 X-ray Exam _____
 Lab Exam _____
 Last Physical _____

FEMALE ONLY

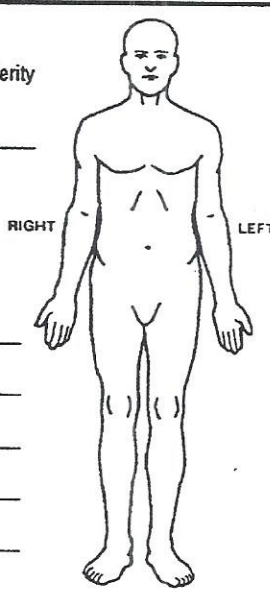
Papsmear _____
 Breast exam _____
 Implants _____

DOCTORS USE ONLY



LEFT RIGHT

SEVERITY OF PAIN
 List region of pain and circle severity number. [1 = least, 10 = greatest]
 ex. Neck
 1 2 3 4 5 6 7 8 9 10



RIGHT LEFT

MARK PAIN AREA

+++	Burning
000	Stabbing
---	Sharp
	Constant

1. _____
 2. _____
 3. _____
 4. _____
 5. _____

Please mark area of pain on the drawing using the code listed above.

HABITS

Smoking Packs/Day _____
 Drinking Alcohol _____
 Coffee Cups/Day _____

EXERCISE

None
 Moderate
 Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

____ 541 Appendicitis	____ 285.9 Anemia	____ 429.9 Heart Disease	____ 716.9 Arthritis
____ 541 Pneumonia	____ 285.9 Measles	____ 429.9 Goiter	____ 716.9 Epilepsy
____ 541 Rheumatic Fever	____ 285.9 Mumps	____ 429.9 Influenza	____ 716.9 Mental Disorder
____ 541 Polio	____ 285.9 Chicken Pox	____ 429.9 Pleurisy	____ 716.9 Lumbago
____ 541 Tuberculosis	____ 285.9 Diabetes	____ 429.9 Alcoholism	____ 716.9 Eczema
____ 541 Whooping Cough	____ 285.9 Cancer	____ 429.9 Venereal Infection	____ AIDS

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if never. A complete history and understanding of your health will facilitate care.

GENERAL SYMPTOMS		GASTRO-INTESTINAL		EYE/EAR/NOSE/THROAT		RESPIRATORY	
___ 784.0	Headache	___ 783	Poor Appetite	___ 368.9	Poor Vision	___ 786.2	Chronic Cough
___ 780.6	Fever	___ 536.8	Poor Digestion	___ 378.9	Crossed Eyes	___ 786.3	Spitting Blood
___ 780.9	Chills	___ 994.2	Excessive Hunger	___ 379.91	Pain in Eyes	___ 933.1	Spitting Phlegm
___ 780.8	Night Sweats	___ 787.3	Belching or Gas	___ 389.9	Deafness	___ 786.50	Chest Pain
___ 780.2	Fainting	___ 787	Nausea	___ 388.70	Earache	___ 786.09	Difficulty Breathing
___ 780.4	Dizziness	___ 787	Vomiting	___ 388.30	Ear Noises		
___ 780.3	Convulsions	___ 578	Vomiting Blood	___ 388.60	Ear Discharges		
___ 780.52	Loss of Sleep	___ 536.8	Pain over Stomach	___ 478.1	Nasal Obstruction		
___ 780.7	Fatigue	___ 564	Constipation	___ 784.7	Nose Bleeds		
___ 799.2	Nervousness	___ 558.9	Diarrhea	___ 462	Sore Throats	GENITO-URINARY	
___ 783	Loss of Weight	___ 789	Colon Trouble	___ 784.49	Hoarseness	___ 788.3	Frequent Urination
___ 782	Numbness or pain in arms/legs/hands	___ 455.6	Hemorrhoids (Piles)	___ 477.9	Hay Fever	___ 788.1	Painful Urination
___ 995.3	Allergy (What)	___ 785.1	Liver Trouble	___ 493.9	Asthma	___ 599.7	Blood in Urine
___ 786.09	Wheezing	___ 782.4	Jaundice	___ 460	Frequent Colds	___ 592	Kidney Infection
___ 729.2	Neuralgia	___ 575.9	Gall Bladder Trouble	___ 240.9	Enlarged Thyroid	___ 788.3	Bed Wetting
				___ 463	Tonsillitis	___ 788.1	Inability to control Urine
				___ 686.9	Sinus Trouble	___ 601.9	Prostate Trouble

MUSCLE & JOINTS		CARDIO-VASCULAR		SKIN OR ALLERGIES		FOR WOMEN ONLY	
___	Weakness	___ 783	Rapid Heart	___ 368.9	Skin Eruptions	___ 786.2	Painful Periods
___	Twitching	___ 427.89	Slow Heart	___ 698.9	Itching	___ 626.2	Excessive Flow
___ 847	Stiff Neck	___ 401.9	High Blood Pressure	___ 278.8	Bruising Easily	___ 626.4	Irregular Cycle
___ 722.10	Backache	___ 458.9	Low Blood Pressure	___ 701.1	Dryness	___ 627.2	Hot Flashes
___ 719	Swollen Joints	___ 786.51	Pain over Heart	___	Boils	___ 625.3	Cramps or Backaches
___ 781	Tremors	___ 438	Previous Heart Trouble	___ 782	Sensitive Skin	___ 634.9	Miscarriage
___ 729.5	Foot Trouble	___ 719.07	Swelling Ankles	___ 708.9	Hives or Allergy	___ 623.5	Vaginal Discharge
___ 724.79	Painful Tail Bone	___ 759.9	Poor Circulation	___ 692.9	Eczema	___	Pregnant at this Time
___ 724.5	Pain Between Shoulders	___	Varicose Veins	___	Medicines	___	Last Pap
___ 563.3	Hernia	___ 436	Strokes	___	___	By Who	___
___ 737.3	Spinal Curvature			___	___	Other	___

OPERATIONS AND PROCEDURES

DATE	Vaccinations	DATE	Tubes in Ears	DATE	Sinus
___	Tonsillectomy	___	Appendectomy	___	Hernia
___	Gall Bladder	___	Female Organs	___	Thyroid
___	Back Operation	___	Rectal Surgery	___	Stomach
___	Other	___	Other	___	Other

List any accidents or falls and dates: Car ___ Recreational Vehicle ___ Sports ___
 School ___ Other ___

List any broken bones or dislocations (fractures): _____

Ever on crutches? No Yes Why? _____

Have you ever had any spinal taps or spinal injections? Yes No

Were you ever knocked unconscious? Yes No

Have you ever had a lapse of memory? Yes No

Have you ever had x-rays taken? No Yes When? _____ By whom? _____

For what ailments were these pictures made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or patent? No Yes What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature X _____ Date _____



ACTIVITIES OF LIFE

Patient's Name: _____ # _____ Date: _____

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of life:

	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Carrying Groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit to Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/> _____ step(s)	<input type="checkbox"/> _____ step(s)	<input type="checkbox"/>
Pet Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Extended Computer Use	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading/Concentration	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/> Upper/lower garments	<input type="checkbox"/> Upper/lower garments	<input type="checkbox"/>
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Yard Work	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Sweeping/Vacuuuming	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Dishes	<input type="checkbox"/>	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/> _____ minute(s)/hour(s)	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Garbage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature: _____ Date: _____

NORTH MARIETTA CHIROPRACTIC CENTER

QUADRUPLE VISUAL ANALOGUE SCALE

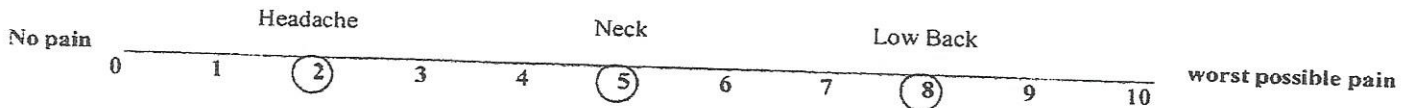
Patient's Name: _____ # _____ Date: _____

Please read carefully:

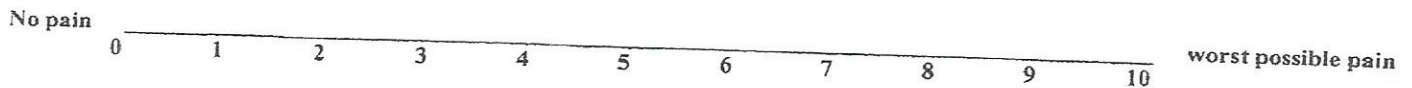
Instructions: Please circle the number the best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain and pain at its best and worst.

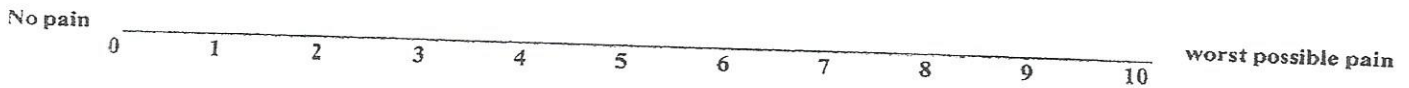
Example:



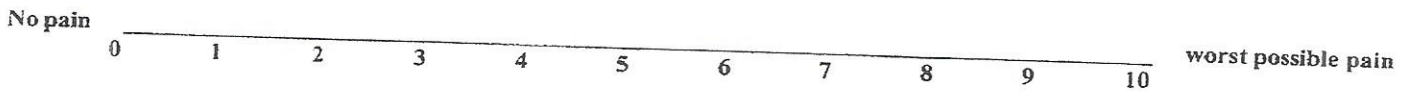
1 - What is your pain RIGHT NOW?



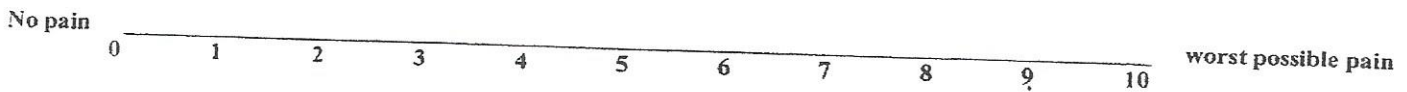
2 - What is your TYPICAL or AVERAGE pain?



3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

CALCULATION: (Add 4 scores) _____ ÷ 4 _____ x 10 = OATS SCORE _____



**NORTH
MARIETTA**

Chiropractic Center

Dr. Gregory J. Krown

145 North Marietta Pkwy NE, Marietta, GA 30060

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DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Chiropractic Physicians are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic test, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through reduction of the VAA or VSC since there are so many variables; it is difficult to predict the time schedule or efficacy of the Chiropractic Procedures. Sometimes the response is phenomenal.

In most cases there is more gradual, but quite satisfactory response. Occasionally, the results are less expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond chiropractically may come under the control or be definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

The Patient should discuss any questions or problems with the doctor before signing this statement of policy.

I have read the foregoing and understand it.

Patient Signature

Date

Witness

Date



**NORTH
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CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

AUTHORIZATION AND ASSIGNMENT

In Consideration of your undertaking to care for 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 or adjuster 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.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you 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 believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve 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 the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and /or recovery in this state, _____.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed, _____, are paid in full.

Signature

Date

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to administer chiropractic care as he/she deems necessary to my _____ (indicate relationship of child).

Name (child's Name)/ (Nombre del Menor)

City & State where this was signed

Date/ (Fecha) Signature/ (Firma)

Date

Witness Signature



This is an agreement between the undersigned _____, and North Marietta Chiropractic, hereinafter called "provider," for full and complete payment of the provider's medical/healthcare services and expenses by the patient from the proceeds of any insurance settlement, judgment at trial, or recovery from any other means or sources. The provider's treatment or medical/healthcare bills were used in settlement, judgment, or recovery.

In consideration the provider hereby agrees upon reasonable request and appropriate authorization, reports of care to the patient's attorney without charge to patient or patient's attorney.

In further consideration the provider agrees upon reasonable request and appropriate authorization to meet with patient's attorney to discuss the treatment of the patient. Such meeting shall be of reasonable duration in consideration of patient's condition and shall be with out charge to patient or attorney.

Patient agrees to pay provider regardless of the outcome of any case, claim or litigation in which the provider's reports, notes, care and treatment plan are used.

Following the outcome of the claim, case or litigation, of collection becomes necessary, patient will then become liable for interest at the highest current legal rate and provider's attorney fees and expenses for successful collection of fees for service.

The attorney acknowledges receipt of contract and patient requests the attorney follow these directions in making payment from any recovery to the undersigned provider.

This agreement shall follow the patient and binds all attorneys or firms handling the patient's case.

Patient directs his/her attorney to withhold payment of the provider's total bill for services/expenses for any settlement or recovery from whatever source and to make payment immediately to the provider.

Patient directs and authorizes attorney to provide provider upon verbal or written request, to release to provider a copy of settlement statement, and settlement check.

This is an obligation coupled with an interest. It is NOT an agreement for payment based upon the outcome of any claim or litigation.

If any clause or provision of this agreement becomes illegal, invalid, or unenforceable for any reason it is the intent of the parties that the remaining part of this agreement not thereby be affected.

This agreement does not waive any right of the provider or preclude the provider from any reasonable actions to collect.

Read, understood, agreed and signed by these parties on this date ___/___/____.

Provider

Patient

Attorney



**NORTH
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Chiropractic Center

The new Georgia Bar Association lien holder rule In 1.15(l) is:

(b) For the purpose of this Rule, a lawyer may not disregard a third person's interest in funds or other property in the lawyer's possession if:

- (1) The interest is known to the lawyer and
- (2) The interest is based upon one of the following:
 - (i) A statutory lien;
 - (ii) A final judgement addressing disposition of those funds or property; or
 - (iii) A written agreement by the client or the lawyer on behalf of the client guaranteeing payment out of those funds or property.

The lawyer may disregard the third person's claimed interest if the lawyer reasonably concludes that there is a valid defense to such lien, judgment or agreement.

(c) Upon receiving funds or other property in which a client or third person has an interest, a lawyer shall promptly notify the client or third person. Except as stated in this Rule otherwise permitted by law or by agreement with the client, a lawyer shall promptly deliver to the client or third person any funds or other property that the client or third person is entitled to receive and, upon request by the client or third person, shall promptly render a full accounting regarding such property.



**NORTH
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Marietta, GA 30060-8023

Chiropractic Center

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FAX (770) 426-1974

RE: Our Patient: _____
Date of Birth: _____

I do hereby authorize _____ (hereinafter referred to as "doctor") to furnish my attorney with a full report of my case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident which occurred on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment or verdict as a result of said accident and authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for services rendered to me and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor's services.

I fully understand I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____

Witness: _____

The undersigned, being attorney of record for the above listed patient, does hereby acknowledge receipt of the above lien and does agree to honor the same to protect the above named doctor's services. In consideration of this agreement the doctor agrees to meet with the attorney following reasonable notice and at mutually agreeable times. In further consideration of this agreement the doctor agrees to provide the attorney with a narrative report upon request by the attorney.

Attorney Name: _____

Attorney Signature: _____ Date: _____

Witness: _____

North Marietta Chiropractic Center

Automobile Accident History Form

YOUR NAME: _____ TODAY'S DATE: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

CITY OF ACCIDENT: _____ STREET OF ACCIDENT: _____

CLOSEST INTERSECTION: _____ NAME OF AT-FAULT DRIVER: _____

Road conditions at the time of the accident: WET DRY ICY OTHER _____

Did the police come to the scene of the accident? YES NO

Is there a report? YES NO

Did you go to the hospital? YES NO

If YES, what is the name and city of the hospital? _____

How did you get to the hospital? _____

What parts of your body was x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

On what part of the automobile did your following body parts hit?

HEAD HIT _____ CHEST HIT _____

RIGHT/LEFT SHOULDER HIT _____

RIGHT/LEFT ARM HIT _____

RIGHT/LEFT HIP HIT _____

RIGHT/LEFT LEG HIT _____

RIGHT/LEFT KNEE HIT _____

OTHER _____

Did you receive any injury or bruise from the seatbelt? YES NO

If YES, please describe. _____

Where did you feel pain immediately after the accident? _____

What bleeding cuts did you sustain during the accident? _____

What bruises did you sustain during the accident? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? YES NO

If YES, how and when? _____

Where were you seated in the vehicle? _____

Was the trunk of your body pointed straight forward at the time of the collision? YES NO

If NO, how was it turned? _____

Was your head pointed straight forward? YES NO

If NO, what direction was it turned and how? _____

Were you aware of the approaching collision prior to the impact, or did the impact catch you by surprise?

AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO

For how long? _____

Did you experience a flash of light or explosion in your head? YES NO

(continued on back of sheet)

Did you become: CONFUSED DISORIENTED LIGHT-HEADED DIZZY NAUSEATED
BLURRED VISION RINGING/BUZZING IN EARS from the accident? (please circle)
If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following? (please circle)

RESTLESSNESS	REDUCED TOLERANCE TO ALCOHOL
DIFFICULTY CONCENTRATING	DIFFICULTY WITH MEMORY
SLEEPLESSNESS	FORGETFULNESS
REDUCED TOLERANCE TO HEAT	IRRITABILITY

How far is the top of the headrest or seatback from the top of your head?
(approximately): _____ inches ABOVE BELOW

Were you wearing a seatbelt? YES NO

If YES, was it a lap seatbelt _____ shoulder-lap seatbelt _____

List the year, make, and model of the vehicle you were in? _____
YEAR _____ MAKE _____ MODEL _____

Was your car stopped at the time of impact? YES NO

If YES, was the driver's foot also on the brake? YES NO

If NO, then estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it:

Slowing down? YES NO

Gaining speed? YES NO

Traveling at a steady rate of speed? YES NO

What is the estimated cost of damage to the vehicle you were in? _____

Which of the following car parts broke during the accident? (please circle)

WINDSHIELD	RIGHT/LEFT SIDE WINDOW	STEERING WHEEL
FRONT/BACK SEAT	OTHER _____	

What is the year, make, and model of the other vehicle?

YEAR _____ MAKE _____ MODEL _____

Was the other vehicle moving at the time of the collision? YES NO

If YES, what was its approximate speed? _____ mph

If the other vehicle was moving at the time of impact, was it:

Slowing down? YES NO

Gaining speed? YES NO

Traveling at a steady rate of speed? YES NO

Please describe, to the best of your knowledge, what happened during this accident:



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Dr. Gregory J. Krown
TEL: (770) 426-9707 ♦ Fax: (770) 426-1974

OFFICE POLICY AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

GENERAL INFORMATION

This authorization is requested by North Marietta Chiropractic Center for its own use/disclosure of protected health information. (*Minimum necessary standards apply.*) You have the right to inspect or copy the PHI to be used/disclosed. You have the right to refuse to sign this authorization. If you refuse to sign this authorization, North Marietta Chiropractic will not refuse to provide treatment. A copy of the signed authorization will be provided to you upon request.

SPECIFIC AUTHORIZATIONS

The patient identified above authorizes and grants permission for North Marietta Chiropractic to use and/or disclose protected health information (i.e., address, phone number, and/or clinical records) in the following ways:

- Birthday cards
- Office marketing material
- Photo Board
- Holiday-related cards
- Patient Referral Board
- Thank You gifts/cards
- Newsletters
- New Patient Board
- Appointment reminders

I also give North Marietta Chiropractic permission to treat me in an "open-room environment" whereas the door to the room will remain open. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will close the door to the room for these conversations.

By signing this form you are giving North Marietta Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above unless indicated otherwise and to treat you in an open-room environment.

This authorization shall expire on the following date: _____

Signature of patient (parent/guardian if patient is a minor)

Date _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization in whole or part, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.



**NORTH
MARIETTA**

Chiropractic Center

145 North Marietta Pkwy NE, Marietta, GA 30060

Dr. Gregory J. Krown
TEL: (770) 426-9707 ♦ Fax: (770) 426-1974

To: _____

Fax: _____

From: _____

RECORDS RELEASE

RE: Patient's Name: _____

Date of Birth: _____

To _____, I hereby authorize you to release to North Marietta Chiropractic Center any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

Signature

Date

Witness Signature

Date

___ Please fax all medical records to: (770) 426-1974

___ Please mail all medical records to: 145 North Marietta Pkwy NE, Marietta, GA 30060

___ Please mail a copy of patients X-RAY / MRI / CT to: 145 North Marietta Pkwy NE, Marietta, GA 30060

___ Patient is currently in our office.



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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PATIENT PRIVACY PRACTICES**

I have read or been provided with a *Notice of Patient Privacy Practices* that provides a description of healthcare information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or Disclosed to carry out treatment, payment, or healthcare operations.

Patient Signature

Date