revive
HEALTH CENTER & SPA

CONFIDENTIAL HEALTH INFORMATION

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.

Kellie C. Baxter, DC
Specializing in Chiropractic and Injury
6875 Hickory Road • Suite 110
Woodstock, GA 30188
Phone 770-345-1111
www.ReviveHealthandSpa.com

Today's Date (MM/DD/YYYY) **Whom may we thank for referring you?/How did you hear about us?**

Have you consulted a chiropractor before? ◯ No ◯ Yes **If so, whom?** **When?**

Gender ◯ Male ◯ Female

Your Last Name **First Name** **Middle Name (Or Initial)**

Your Social Security Number **Birth Date (MM/DD/YYYY)** **Emergency Contact Name & Phone**

Home Phone **Cell Phone** **May we contact you at work?** ◯ Yes ◯ No **Work Phone**

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Spouse's Name

Spouse's DOB

Email Address

Children's Names and Ages

Address

City **State/Province** **ZIP/Postal Code**

Occupation

Employer

Employer Address

Your Primary Medical Care Provider's Name

City **State/Province** **ZIP/Postal Code**

Your Primary Medical Care Provider's Phone

Your Insurance Carrier **Policy Number**

Who carries this policy? ◯ Self ◯ Spouse ◯ Parent

Insured's Last Name

Insured's DOB

First Name **Middle Name (or Initial)**

Insured's Employer

Address

City **State/Province** **ZIP/Postal Code** **Employer's Phone**

Secondary Insurance Carrier **Policy Number** **Who carries this policy?** ◯ Self ◯ Spouse ◯ Parent

I certify that any changes to my personal information have been updated above for your records.

Signature

Patient Signature (Parent or Guardian's signature if patient is a minor)

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: ______

Patient name ______

2. And are the result of (darken circle): ◯ An accident or injury ◯ Work ◯ Auto ◯ Other ______
◯ A worsening long-term problem ◯ An interest in: ◯ Wellness

3. Onset (When did you first notice your current symptoms?) ______

4. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Come and goes. How Often? ______

5. Intensity/How extreme are your current symptoms? (Fill in bubbles below)

Absent Uncomfortable Agonizing

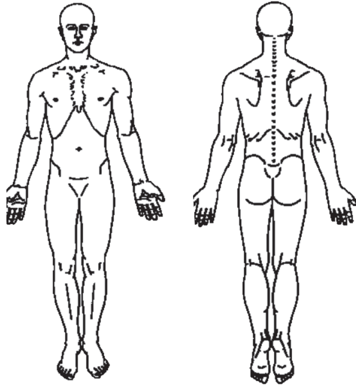
8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

______

6. Quality of symptoms
(What does it feel like?)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other

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



9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? ______

What tends to lessen the problem? ______

10. Prior interventions (What have you done to relieve the symptons?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other ______
◯ Physical therapy ◯ Massage ______

11. What else should Dr. Baxter know about your current condition? ______

12. Does your current condition interfere with your: ◯ Work ◯ Sleep ◯ Recreational activities ◯ Household responsibilities ◯ Personal relationships

Consultation Notes

13. Review of Systems
Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	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		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	NONE ◯ Initials ___

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	NONE ◯ Initials ___

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	NONE ◯ Initials ___

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	NONE ◯ Initials ___

◯ All other systems negative

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	NONE ◯ Initials ___

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	NONE ◯ Initials ___

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 change	◯	◯	Weakness	NONE ◯ Initials ___

______
Doctor's Initials
Dr. Kellie C. Baxter BS, DC

Patient name

Past Personal, Family and Social History
Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

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

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

15. 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: ____________
- ○ Metal pins, plates or screws: *Where?* ____________

16. 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

17. 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
○	○	Nutritional supplements:
○	○	Prescription Medications
○	○	Over-the-counter Medications

List prescription medications, over-the-counter medications and nutritional supplements you are currently taking: ____________

FAMILY

18. Family History
Some health issues are hereditary. Tell Dr. Baxter about the health of your immediate family members.

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	____	○	○	____	____	○	○

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

SOCIAL

20. Social History
Tell Dr. Baxter about your health habits and stress levels.

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? ____
Recreational drugs?	○ Daily	○ Weekly	How much? ____

Job pressure/stress? ○ Yes ○ No

Vaccinated? ○ Yes ○ No

Hobbies: ____________

Consultation Notes

Doctor's Initials
Dr. Kellie C. Baxter BS, DC

Patient name

Consultation Notes

21. Activities of Daily Living

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

Activity	No Affect	Mild Affect	Moderate Affect	Severe Affect
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	◯	◯	◯	◯

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

22. What is the major stressor in your life? ______

23. How much sleep do you average per night? ______ Hours

24. What is the type and approximate age of your mattress and pillow? ______

25. What is your preferred sleeping position? ______

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

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

28. 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 judgment, 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.**

If the patient is a minor child, print child's full name: ______

Doctor's Initials

Dr. Kellie C. Baxter BS, DC

Signature ______ Date (MM/DD/YYYY) ______