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 USE INK AND 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)** _____

Birth Date (MM/DD/YYYY) _____ **Emergency Contact Name** _____ **Emergency Contact Phone** _____

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

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

Email Address _____ **Spouse's Name** _____

Spouse's DOB _____

Address _____ **Occupation** _____

City _____ **State/Province** _____ **ZIP/Postal Code** _____ **Your Primary Medical Care Provider's Name** _____

Employer _____ **Your Primary Medical Care Provider's Phone** _____

Employer Address _____ **Date of Last Physical Exam** _____

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

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: _____

_____

_____

2. And are the result of (darken circle): ◯An injury ◯Work ◯Auto Accident ◯A worsening long-term problem ◯Wellness ◯Other _____

3. Onset (Date you first noticed your current symptoms) _____ Pain is worse in ◯ Morning ◯ Evening?

4. Duration and Timing (How often do you feel it?) ◯ Constant 100% ◯ Frequent 75% ◯ Intermittant 50% ◯ Occasional 25%

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

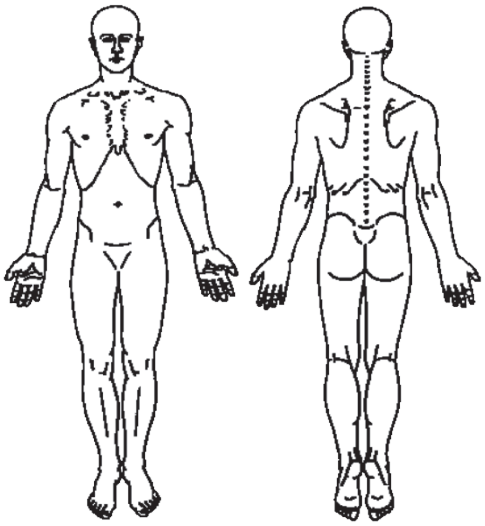
6. Aggravating or relieving factors (What makes it better or worse, such as certain movements or activities, etc.)

What tends to worsen the problem? _____ What tends to lessen the problem? _____

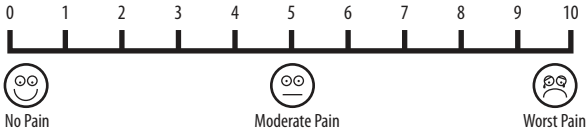
7. Quality of symptoms (What does it feel like?)

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

8. Location (Where does it hurt?) Circle the area (s) on the illustration.



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



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

13. Activities of Daily Living

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

	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	◯	◯	◯	◯

	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	◯	◯	◯	◯

Patient name

Consultation Notes

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

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

Patient name

PERSONAL

Hospitalizations: Please list any times you have been hospitalized and why:

_____

_____

Operations / Surgeries : Please list any procedures which may or may not have included hospitalization.

_____

_____

Prior Accidents / Injuries: Please list any prior accidents , injuries, fractures, concussions you have had.

_____

_____

Illnesses: Please list any ongoing illnesses you have.

_____

Previous Tests / Medical Procedures : Please list any tests or procedures you have had that relate to your complaint.

_____

Sexual History: Please list any pertinent sexual history if applicable.

_____

Allergies: Please list any ongoing allergies you have.

_____

Medications: Please list all current prescribed medications and over the counter medications you are taking and what for.

_____

_____

Nutritional Supplements: Please list any supplements you are taking and what for.

_____

Describe your dietary habits: ◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

Prior Chiropractic Care: Please list any previous chiropractic care you have had, and how long ago.

_____

Treatments: Please list bubble in any of the following treatments you have had or are currently having:

◯ Acupuncture ◯ Birth control pills ◯ Blood transfusions ◯ Chemotherapy ◯ Dialysis ◯ Hormone replacement

◯ Massage therapy ◯ Physical therapy ◯ Herbs ◯ Essential Oils ◯ Homeopathy

Consultation Notes

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

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	◯	◯	_____	_____	◯	◯
Father	_____	◯	◯	_____	_____	◯	◯
Sisters	_____	◯	◯	_____	_____	◯	◯
Brothers	_____	◯	◯	_____	_____	◯	◯

16. Are there any other hereditary health issues that you know about? _____

_____

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

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

SOCIAL

Coffee Use ◯ Daily ◯ Weekly How much? _____
Soft drinks ◯ Daily ◯ Weekly How much? _____
Water intake ◯ Daily ◯ Weekly How much? _____
Pain relievers ◯ Daily ◯ Weekly How much? _____
Recreational drugs? ◯ Daily ◯ Weekly How much?
Do you have any Pins, plates, or screws? If Yes, where? _____

Job pressure/stress? ◯ Yes ◯ No
Do you have any Tatoos? ◯ Yes ◯ No
Do you have any Piercings? ◯ Yes ◯ No
Childhood Vaccinations? ◯ Yes ◯ No
Recent Vaccinations? _____
Hobbies: _____

18. What is the major stressor in your life? _____

19. How much sleep do you average per night? _____Hours

20. What is the type and approximate age of your mattress and pillow? _____

21. What is your preferred sleeping position? _____

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

23. 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: _____

Signature

Date (MM/DD/YYYY)

Patient name

Consultation Notes

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