KEYSTONE CHIROPRACTIC
Associates of Newnan, LLC.

General Patient Information Questionnaire

Thank you for choosing Keystone Chiropractic Associates for your chiropractic care. It is our mission to provide patients with the highest quality primary holistic musculoskeletal healthcare.

By completing the requested information you will better assist us in being able to determine the course of appropriate care for your particular health concerns. Feel free to complete this questionnaire at your convenience prior to your visit with us and simply bring it with you to your confirmed appointment. If you have any questions, feel free to contact our office at 678-673-6552.

Office Use Only:
*P File#:*_____
*R File#*_____

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General Patient Information

(To be completed by patient or legal guardian and returned to the receptionist)

Please Print:
Today's date: _____ Date of Birth: _____ Age: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: ____ Male ____ Female

Is there another name that you prefer to be called?: _____

Are you seeking care due to an auto accident or job-related injury? ☐ Yes ☐ No

Home Address *line 1:* _____

Home Address *line 2:* _____

Home City: _____ State: _____ Zip: _____

Phone: H: _____ W: _____ C: _____

Email: _____

Occupation: _____ Employer: _____

Work Address line 1: _____

Work Address line 2: _____

Work City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name *(if appl.)* _____

Spouse's Contact Phone: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Spouse's Work Address line 1: _____

Spouse's Work Address line 2: _____

Work City: _____ State: _____ Zip: _____

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General Patient Information

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Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: _____

Have you Received Chiropractic Care in the past?: ☐ Yes ☐ No

If yes, please provide the name of the chiropractor: _____
What was the reason for previous chiropractic care?: _____
_____
_____

Name of medical doctor: _____
Phone of medical doctor: _____

Who is your insurance company?: _____
Group/Policy number of insurance company: _____

What is your primary reason for seeking chiropractic care? _____
_____
_____
_____

Please answer the following to the best of your ability:
In general, would you say that your health is?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you now or have you ever smoked tobacco products? ☐ Yes ☐ No

If yes, how much and how often? _____
_____

Do you now or have you ever consumed alcohol? ☐ Yes ☐ No

If so, how much and how often? _____
_____

Can you think of any other habit or activity that you participate in that has a negative effect on your health? _____

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Please indicate any and all medications as well as amounts of those medications that you are currently taking (prescription as well as over the counter medications (OTC).

_____

_____

_____

Please indicate if you have, or have had, any of the following:

	Yes	No		Yes	No
Back Pain	☐	☐	Prostate Problems	☐	☐
Neck Pain	☐	☐	Difficulty Urinating	☐	☐
Shoulder/Arm Pain	☐	☐	Kidney Problems	☐	☐
Hip/Leg Pain	☐	☐	Menstrual Problems	☐	☐
Sciatica	☐	☐	Pregnancy	☐	☐
Arthritis	☐	☐	Colon Problems	☐	☐
Headache	☐	☐	Stomach Problems	☐	☐
Dizziness	☐	☐	Liver Problems	☐	☐
Chest Pain	☐	☐	Frequent Infections	☐	☐
Poor Circulation	☐	☐	Skin Problems	☐	☐
Irregular Heart Beat	☐	☐	Easy Bruising	☐	☐
High/Low Blood Pressure	☐	☐	Cancer	☐	☐
Difficulty Breathing	☐	☐	Been hospitalized	☐	☐
Asthma	☐	☐	Broken a bone	☐	☐
Had surgery	☐	☐	Emotional Disorders	☐	☐
Been Bedridden	☐	☐	An Infectious Disease	☐	☐

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To your knowledge, are there any other personal health conditions that are, or have in the past affected you? _____
_____
_____

Do you have any piercings or tattoos? ☐ Yes ☐ No

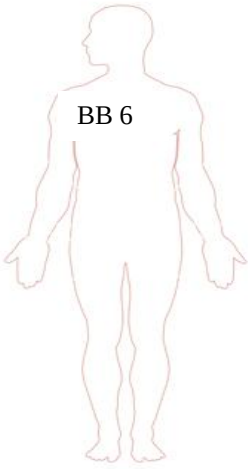
If yes, where? _____
_____

Using the following diagrams, please indicate the area(s) of injury or discomfort that you are seeking care for: (For each area, indicate the level of discomfort on a scale of 1-10; 1= very mild/barely noticeable and 10=unbearable) (See example below)

NN Numbness
PP Pins & Needles
BB Burning
AA Aching
SS Stabbing

Example: burning feeling in the right chest that is 6/10 in pain

Front



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KEYSTONE CHIROPRACTIC
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General Patient Information

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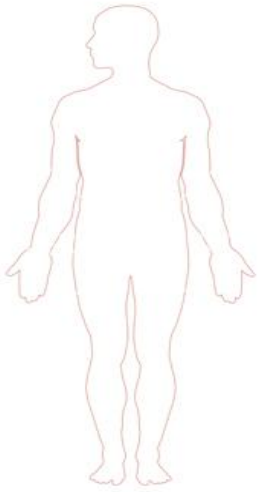
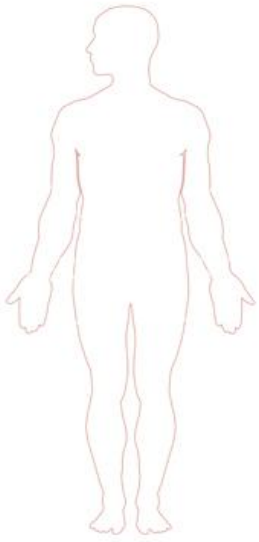
Your Front



Your Back



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General Patient Information

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By signing this application, you agree that 1) you are consenting to delivery of professional examination and written recording of your personal health history, 2) that you are the individual represented by, or the legal guardian for the individual represented by the information above, 3) the information that you have provided above is current and accurate to the best of your knowledge and that no intentional omissions or falsifications have been completed, and 4) you are the responsible party for all charges and financial responsibilities incurred for services provided.

Additionally, by signing below, you affirm that your request for chiropractic care is not due to current or pending litigation.

_____ _____
Patient Name Name of legal guardian (if patient is a minor)

_____ _____
Signature of Patient (or legal guardian) Date Signed

Insurance Patients Only:

Keystone Chiropractic Associates of Newnan, LLC will gladly bill your insurance company(s) for services that are rendered to you or your family (if covered by your insurance company and policy) on your behalf. The financial obligation of receiving healthcare services however, remains the responsibility of the patient or their legal guardian. Pending the arrangement that you have with your insurance company(s), you may also be responsible for co-pays and/or out of pocket deductibles according to the policy. By signing below, you understand the obligation that is here described to you and that you agree to release health insurance payments to Keystone Chiropractic Associates of Newnan, LLC to cover costs incurred.

_____ _____
Patient Name Name of legal guardian (if patient is a minor)

_____ _____
Signature of Patient (or legal guardian) Date Signed