

# Pine Mountain Chiropractic Center

"Where Families Come to Get Healthy & Stay Healthy!"



706-663-8801

Dr. Jeffery A. Russell

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Pine Mountain, Georgia

[www.PineMountainChiropractic.com](http://www.PineMountainChiropractic.com)

## Confidential Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: (circle) Male or Female Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Email \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse or Parent's (if minor) Name \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

## How do you plan to pay for your office visit today?

- Cash
- Check
- Credit/Debit Card (MC/VISA/AmExpress/Discover)
- Insurance (Name of Carrier \_\_\_\_\_ Insured's Name \_\_\_\_\_)  
Insured's Date of Birth \_\_\_\_\_ (Deductible Met? Circle Yes or No)
- Medicare (Deductible Met? Circle Yes or No)
- Secondary Ins. (Name of Carrier \_\_\_\_\_ Insured's Name \_\_\_\_\_)  
Insured's Date of Birth \_\_\_\_\_ (Deductible Met? Circle Yes or No)
- Other: \_\_\_\_\_

## Symptoms

Reason for visit: \_\_\_\_\_ When did you first notice symptoms? \_\_\_\_\_

What caused the condition? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

Where specifically is the problem(s) located? \_\_\_\_\_

Which activities are difficult to perform? (Circle) Sitting Standing Walking Bending Lying Down

Type of pain: (Circle All that Apply) Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other: \_\_\_\_\_

Rate the severity of your pain (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? \_\_\_\_\_

What treatment have you already received for your condition? (Circle)

Medication Surgery Physical Therapy Chiropractic Other: \_\_\_\_\_

Name and Location of other doctor(s) who have treated you for your conditions: \_\_\_\_\_

Please see Side on Reverse

## Health History

Circle any conditions which are applicable throughout your *lifetime*:

AIDS/HIV	Alcoholism	Allergy Shots	Anemia	Anorexia
Appendicitis	Arthritis	Asthma	Bleeding Disorders	Breast Lump
Bronchitis	Bulimia	Cancer	Cataracts	Chemical Dependency
Chicken Pox	Depression	Diabetes	Emphysema	Epilepsy
Fractures	Glaucoma	Goiter	Gonorrhea	Gout
Heart Disease	Hepatitis	Hernia	Herniated Disc	Herpes
High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Measles
Migraine Headache	Miscarriage	Mononucleosis	Multiple Sclerosis	Mumps
Osteoporosis	Pacemaker	Parkinson's Disease	Pinched Nerve	Pneumonia
Polio	Prostate Problem	Prosthesis	Psychiatric Care	Rheumatoid Arthritis
Rheumatic Fever	Scarlet Fever	Stroke	Suicide Attempt	Thyroid Problems
Tonsillitis	Tuberculosis	Tumors, Growths	Typhoid Fever	Ulcers
Vaginal Infection	Venereal Disease	Whooping Cough	Other: _____	

**Dates and type of last exams** (physical, routine or other exams)

\_\_\_\_\_

List any types of surgeries which you have had and the dates which they occurred:

Describe any accidents which you have had and the dates which they occurred: \_\_\_\_\_  
Are there any law suits pending? \_\_\_\_\_

Please list all medications you are currently taking:

Allergies:

**Women Only** → Are you Pregnant? Yes or No    Nursing? Yes or No    Taking birth control pills? Yes or No

## Daily Habits

What type of exercise do you perform on a daily basis?    None    Moderate    Heavy

What do your daily work habits include?

sitting    standing    light labor    heavy labor    computer work    other: \_\_\_\_\_

What vitamins do you currently take? \_\_\_\_\_

What kind of other nutritional supplements do you take (if any)? \_\_\_\_\_

Do you smoke? Yes or No    How much per day? \_\_\_\_\_

How much liquor or alcohol do you consume on a weekly basis? \_\_\_\_\_

How much coffee or caffeinated beverages do you consume on a daily basis? \_\_\_\_\_

## Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Jeffery Russell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Jeffery Russell may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.



\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Relationship to Patient