

Atlanta Injury Specialists

Dr. Karen Isaacson

2879 East Point Street, Suite 11, East Point, Georgia 30344

Ph: 404-209-9277 Fax: 404-209-9477

Thank you for choosing Atlanta Injury Specialists as your Chiropractic and Rehab Therapy service provider.

In order to expedite your initial consultation and exam, please bring the following information with you for your first appointment:

Completed New Patient Paperwork

Drivers License

Personal Health Insurance Card

Any Claim #'s associated with this incident.

*Any and all medical records related to this incident.

* This information may be faxed to our office to **YOUR ATTENTION** at: **404-209-9277**. Or, You may bring it with you on your first visit.

Thank you for your cooperation,

Shannon Hardy

Front Office Manager, Atlanta Injury Specialists

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PAST AND PRESENT GENERAL HEALTH HISTORY PAGE 2

CHECK RECENT OR CURRENT SYMPTOMS

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
<input type="checkbox"/> Headache / Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, Tingling		<input type="checkbox"/> Other:	

SYMPTOM /PAIN DESCRIPTION

Please circle any word(s) below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Acne	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep Pain	Falls Asleep
Irritating	Burning-Hot	Dreadful	Superficial Pain	Suffocating
Annoying	Drill Like	Fearful	Stinging	Punishing
Stiff or Tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

Have you seen any other Medical Providers for this condition?

No, Yes If Yes, Providers Name: _____ Year: _____

Problem seen for: _____

ARE YOU TAKING ANY MEDICATIONS?

I am not taking any medications currently. Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Anacin
<input type="checkbox"/> Anti-Inflammatory	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Bufferin
<input type="checkbox"/> Narcotics for Pain	<input type="checkbox"/> Advil / Motrin	<input type="checkbox"/> Stroke Prevention Meds.
<input type="checkbox"/> Heart Medications	<input type="checkbox"/> Birth Control Medications	<input type="checkbox"/> Other

WHEN IS YOUR PAIN USUALLY BETTER?

<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
<input type="checkbox"/> During Sleep Hours	<input type="checkbox"/> Lying Down Flat	<input type="checkbox"/> Standing
<input type="checkbox"/> Walking	<input type="checkbox"/> Sitting	<input type="checkbox"/> Rest
<input type="checkbox"/> Stress (mental) is Less	<input type="checkbox"/> Good Posture	<input type="checkbox"/> Exercise / Stretching

HAS YOUR PAIN BEEN ASSOCIATED WITH:

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night Pain or night time sweats
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Ovarian Pain	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Low Grade Fever	<input type="checkbox"/> Kidney Pain/Painful Urination	<input type="checkbox"/> Balance Problems

DO YOU EXERCISE?

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to do exercise	<input type="checkbox"/> I am not willing to do exercises	<input type="checkbox"/> I do regular sports activities

Check only those conditions that apply to you and indicate if you have had in the past or presently have:

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	I bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	I heal slowly	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	My body temperature is normally low (feel cold) *	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetic	<input type="checkbox"/>	<input type="checkbox"/>

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<input type="checkbox"/>	Do you have a pacemaker, neck or chest shunt, any problems lying face down?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness, blacked out, or fainting spell history	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion History	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or treatment of any type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (indicate and suspected strokes or transient ischemic attacks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have spina bifida, abdominal aneurysm, or vascular conditions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why?:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Coma from head injury or other problem	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoporosis of your spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Women Only: Check this box if you currently have any type of breast implants	N/A	N/A
<input type="checkbox"/>	Women Only: Check this box if there is any chance that you are currently pregnant	N/A	N/A

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

(I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Bicycle Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain or Arm Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back / Leg Pain	<input type="checkbox"/> Other Pain

FRACTURES / BROKEN BONES

(I have never had any broken bones). If you have broken any bones, indicate where and when:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar Bone (Clavicle)		<input type="checkbox"/> Rib Bone	
<input type="checkbox"/> Arm or Hand Pain		<input type="checkbox"/> Leg or Foot Bone	
<input type="checkbox"/> Pelvis Bone		<input type="checkbox"/> Other	

PREVIOUS SURGERIES

(I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck or back)		<input type="checkbox"/> Appendix	
<input type="checkbox"/> Disc Surgery (neck or back)		<input type="checkbox"/> Gallbladder / Stomach / Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Rib / Collar Bone	
<input type="checkbox"/> Head / Brain		<input type="checkbox"/> Hernia	
<input type="checkbox"/> Shoulder / Arm Leg		<input type="checkbox"/> Other	

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CHIEF Complaints or Symptoms:

Name:

Date:

<input type="checkbox"/> Neck pain check off the areas that the pain runs into from the neck	<input type="checkbox"/> none <input type="checkbox"/> left shoulder <input type="checkbox"/> left arm <input type="checkbox"/> left forearm <input type="checkbox"/> left hand <input type="checkbox"/> right shoulder <input type="checkbox"/> right arm <input type="checkbox"/> right forearm <input type="checkbox"/> right hand
<input type="checkbox"/> Headache	
<input type="checkbox"/> Migraine Headache	
<input type="checkbox"/> Upper back pain	

Ringing in Ears Yes No Left Right Both Ears

Blurry Vision Yes No Left Right Both Eyes

Wrist Pain Yes No Left Right Both Wrists

Jaw Pain Yes No Left Right Both Sides

Dizziness nervousness fatigue anxiety depression excessive irritability

fear of driving in a car a loss of concentration jaw clenching grinding of teeth at night nightmares

difficulty with sleeping at night

<input type="checkbox"/> Low Back Pain select the areas of radiation, if any...	<input type="checkbox"/> none <input type="checkbox"/> buttocks <input type="checkbox"/> left buttock <input type="checkbox"/> left thigh <input type="checkbox"/> left knee <input type="checkbox"/> left foot <input type="checkbox"/> right buttock <input type="checkbox"/> right thigh <input type="checkbox"/> right knee <input type="checkbox"/> right foot
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Hip Pain	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral
Knee Pain	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral
Foot Pain	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral

Numbness:

Left Hand Left Upper Arm Right Hand Right Upper Arm

Left Foot Left Leg Right Foot Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? Yes No

If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? Yes No

Description of previous Accident _____

Description of previous injuries: _____

Is there any residual pain from the previous injury? Yes No

How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

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INFORMED CONSENT FOR TREATMENT

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, 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/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. 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.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by Atlanta Injury Specialists, Inc. and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Atlanta Injury Specialists, Inc.

I have had the opportunity to discuss with the Doctor of Chiropractic the nature and purpose of chiropractic adjustments and other procedures.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature

Date

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our Legal Duty: We have the duty to protect the confidentiality of your medical information. We are required by law to provide you with a Notice of Privacy Practices explaining the ways we may use and disclose your medical information. This Notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information.

Parties Following the Notice: The Notice will be followed by the clinic and its affiliates, together with their healthcare professionals, staff, and volunteers, members of the Clinic's medical staff, and those participating in managed care networks with the clinic: and other legal entities that provide services to the Clinic.

How We May Use and Disclose Your Medical Information: We may use and disclose your identifiable health information for many reasons including:

- Treatment
- Payment
- Healthcare Operations
- Public Health Purposes
- Auditing
- National Security/Protective Services
 - Research
- Workers' Compensation
- Lawsuits and Disputes
- Law Enforcement Purposes
- Activities of Managed Care Networks in which we participate
- Activities of Our Affiliates
- Appointment Reminders
- Fundraising Activities
- Organ Donation
- To Avert a Serious Threat to health or Safety
 - To Coroners, Medical Examiners, and Funeral Directors
- To Military Command Authorities
- As Required by Law

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you, **unless you object in writing or request a limitation of the disclosure**, for:

- Individuals Involved in Your Care or Payment

Your Privacy Rights:

You have the following rights with respect to your health information:

- The Right to Request Confidential Communication and an Alternate means of Communication with you
- The Right to Request Restrictions on Certain Uses of Your Medical Information
- The Right to Inspect and Copy Certain Medical Information that we Maintain about you
- The Right to Request an Amendment of your Health Information
- The Right to Accounting of Certain Disclosures of Your Health Information

Changes to the Notice: We reserve the right to change the Notice. We will post a revised Notice in Atlanta Injury Specialists.

Complaints: If you believe your rights have been violated, you may file a complaint with the office manager of Atlanta Injury Specialists; Jerel Green at 770-454-8300, or you may file a written complaint with the Secretary of The U.S Department of Health and Human Services.

ACKNOWLEDGEMENT

Patient's Name (please print): _____

Patient Acknowledgement: I acknowledge that I have received a copy of the Notice of Privacy Practices for Atlanta Injury Specialists. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Signature of Patient: _____ Date: _____

For Use by Atlanta Injury Specialists Personnel Only: [Complete if patient acknowledgement is not obtained]

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgement was not obtained because, _____

Signature of Atlanta Injury Specialists Representative: _____ Date: _____

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The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgement was not obtained because, _____.

Signature of Atlanta Injury Specialists Representative: _____ Date: _____

Medical Records Release

I, _____, authorize **ATLANTA INJURY SPECIALISTS**

to release my medical records / xrays/ all other test results to:

Atlanta Injury Specialists
2879 East Point Street
Suite 11
East Point, GA 30344

Send records to the attention of: _____

Thanks in advance for your immediate cooperation regarding this matter.

Patient Signature

Date

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X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please Choose One:

_____ I understand that my doctor may need x-rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. I choose not to have any x-rays at this time and release my doctor of all liabilities.

Signature: _____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant _____yes _____no _____ don't know

I could be pregnant _____yes _____no _____ don't know

My menstrual period is late _____yes _____no _____ don't know

I have an IUD _____yes _____no

I have had a tubal ligation _____yes _____no

I have had a hysterectomy _____yes _____no

I have irregular menstrual periods _____yes _____no

My last menstrual period began _____

I have begun menopause _____yes _____no

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ Date: _____