

# 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 Stiggers

Front Office Manager, Atlanta Injury Specialists

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## PATIENT INTRODUCTION FORM

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name:	
Address:	
City/State/Zip:	Home Telephone:
DOB: _____ Age: _____	Work Telephone:
Social Security Number:	Employer Name:
Email Address:	Job Title:
Cell Phone Number:	Marital Status (Circle): Single, Married, Divorced, Widowed

Name, Address, Relationship, and Telephone Number of your nearest relative (for emergencies):

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**\*\*\*Please give the receptionist your driver's license, health insurance card and, if needed, auto insurance card to make a copy for our records.\*\*\***

## INSURANCE COMPANY

Insurance Company Name (Need copy of card).	Carrier Name: _____ Address: _____ Telephone: _____
<b>If you are being seen for a work related or car accident injury, we need the Claim Number and the Claim adjusters Name. If unknown, be certain to let the front desk staff know.</b>	Claim Number: _____ Claim Adjusters Name: _____
Are you the insured person or dependent?	Insured    Dependent ( Wife/Husband/Child )
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, and the name of the insured's employers business in order to do billing	Insured's Name: _____ Social Security Number: _____ Insured's Date of Birth: _____ Insurance Company: _____

***Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, coinsurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.***

Attorney Name \_\_\_\_\_ Phone Number \_\_\_\_\_

I authorize the Doctor and staff to perform medical services on me or my child(ren) and know that I am personally responsible for all services rendered.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## PAST AND PRESENT GENERAL HEALTH HISTORY PAGE 2

### CHECK RECENT OR CURRENT SYMPTOMS

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
Headache / Migraines		Upper Back Pain, Soreness, Stiffness	
Neck Pain, Soreness, Stiffness		Hip Pain	
Low Back Pain, Soreness, Stiffness		Leg or Foot Pain, Numbness, or Tingling	
Arm/Hand Pain, Numbness, Tingling		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.

Muscle Relaxants	Aspirin	Anacin
Anti-Inflammatory	Tylenol	Bufferin
Narcotics for Pain	Advil / Motrin	Stroke Prevention Meds.
Heart Medications	Birth Control Medications	Other

### WHEN IS YOUR PAIN USUALLY BETTER?

Morning	Afternoon	Evening
During Sleep Hours	Lying Down Flat	Standing
Walking	Sitting	Rest
Stress (mental) is Less	Good Posture	Exercise / Stretching

### HAS YOUR PAIN BEEN ASSOCIATED WITH:

Excessive fatigue-malaise	Bowel or bladder disorders	Night Pain or night time sweats
Weight Loss	Ovarian Pain	Abdominal Pain
Low Grade Fever	Kidney Pain/Painful Urination	Balance Problems

### DO YOU EXERCISE?

I do no regular exercise	I exercise 1-2 times a week	I exercise 3-5 times a week
I stretch regularly	I do weight lifting at gym/home	I do cardiovascular work outs
I am willing to do exercise	I am not willing to do exercises	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
	I bruise easily		
	I heal slowly		
	My body temperature is normally low ( feel cold) *		
	Smoke cigarettes or use tobacco products		
	Diabetic		

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

### 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:

Work Injury	Fall	Sports Injury	Lifting Injury	Car Accident
Motorcycle Injury	Bicycle Injury	Pedestrian Injury	Military Injury	Other Injury
Headaches/Migraines	Neck Pain or Arm Pain	Middle Back Pain	Low Back / Leg Pain	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
Spinal Vertebra		Skull	
Collar Bone ( Clavicle )		Rib Bone	
Arm or Hand Pain		Leg or Foot Bone	
Pelvis Bone		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
Spine Surgery ( neck or back )		Appendix	
Disc Surgery ( neck or back )		Gallbladder / Stomach / Kidney	
Heart		Cancer ( any type )	
Tonsillectomy		Rib / Collar Bone	
Head / Brain		Hernia	
Shoulder / Arm Leg		Other	

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## CHIEF Complaints or Symptoms:

Name:

Date:

<input type="checkbox"/> <b>Neck pain</b> 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"/> <b>Low Back Pain</b> 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.

## ASSIGNMENT OF BENEFITS

I hereby authorize, Atlanta Injury Specialists, to release to my insurance company, attorney, or adjuster any information acquired in the course of my examination or treatment.

My attorney and / or insurance company are hereby requested and authorized to pay directly to Atlanta Injury Specialists at 5464 Peachtree Industrial Blvd, Chamblee, GA 30341 any and all outstanding bills for services rendered to me by Atlanta Injury Specialists.

This authorization and direction pertains to any and all sums of money which you may have received on my behalf, but particularly refers to any sums of money which you may have as a result of representing me in the captioned matter.

The only manner in which this authorization may be set aside or voided is by my presenting to you the evidence of payment of any outstanding bills for services rendered to me by Atlanta Injury Specialists.

-----  
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
- 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
- Research

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.

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## 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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## Medical Records Release

I, \_\_\_\_\_, authorize \_\_\_\_\_

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

**ATLANTA INJURY SPECIALISTS**

located at: 2879 East Point Street  
Suite 11  
East Point, GA 30344

Thanks in advance for your immediate cooperation regarding this matter.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Send records to the attention of:

\_\_\_\_\_

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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: \_\_\_\_\_