Middle Georgia Chiropractic

Dr Ron E. Lemon
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(478) 330-5087

Name_____ Sex ☐M ☐F Date_____ Age: _____

Address_____ City _____ State_____ Zip Code _____

Date of Birth_____ Home #: (____) _____Work # :(___) _____ Cell # :(___)_____*

Referred by_____ Social Security #_____ Employer_____

Marital Status ☐ Single☐ Married ☐ Divorced ☐ Other Spouse's name _____

Spouse's employer _____Person responsible for this account: _____

Name of insured: _____ Relationship to patient: _____Insured DOB_____

Insurance Company: _____ Do you have additional insurance: ☐ Yes ☐ No _____

Have you received Chiropractic Care in the past? ☐ Yes ☐ No If yes, when? _____

1. Primary reasons for seeking chiropractic care:

Primary reason (Ex: pain relief, wellness care): _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____ Date complaint began: _____

Cause of complaint (Ex: accident, fall, lifting, gradual onset)? _____

Please circle the type of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Yes No Where? _____

Do you have any numbness or tingling in your body? Yes No Where? _____

Rate the severity of your pain (0=no pain/discomfort, 10=severe pain) 0 1 2 3 4 5 6 7 8 9 10

How frequent is your complaint present? _____ How long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Is the complaint getting: ☐ better ☐ worse ☐ staying the same

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:
Please list all medications you are currently taking and the reason for taking: _____

_____

E. Surgeries
Please list any surgeries you have had and the dates which they occurred: _____

_____

F. Females/ Pregnancies
Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

5. Family Health History:
Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

6. Social and Occupational History:

A. Job description: _____

B. Recreational activities: _____

C. What type of exercise do you perform on a weekly basis? ☐ None ☐ Moderate ☐ Heavy

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

I certify that I, and/or my dependent(s), have insurance coverage with_____, and assign directly to Middle Georgia Chiropractic all insurance benefits, and any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

☐ **By checking this box, I agree to receive texts from Middle Georgia Chiropractic at this mobile number.**

Patient or Guardian Signature _____ Date_____

Doctor's Signature _____ Date _____

Email address (optional) _____