WALKER CHIROPRACTIC

104 Woodland Rd.
Augusta, GA 30907
706.504.3511
AugustaChiro.com

UPDATE FORM

Personal Information

Name: ______________________ Date: ___/___/___

Address: ______________________
Street City ZIP State

E-mail Address: ______________________

Birth Date: ___/___/___ Age: ________ Are you Pregnant? Yes ☐ No ☐ ________ # of weeks

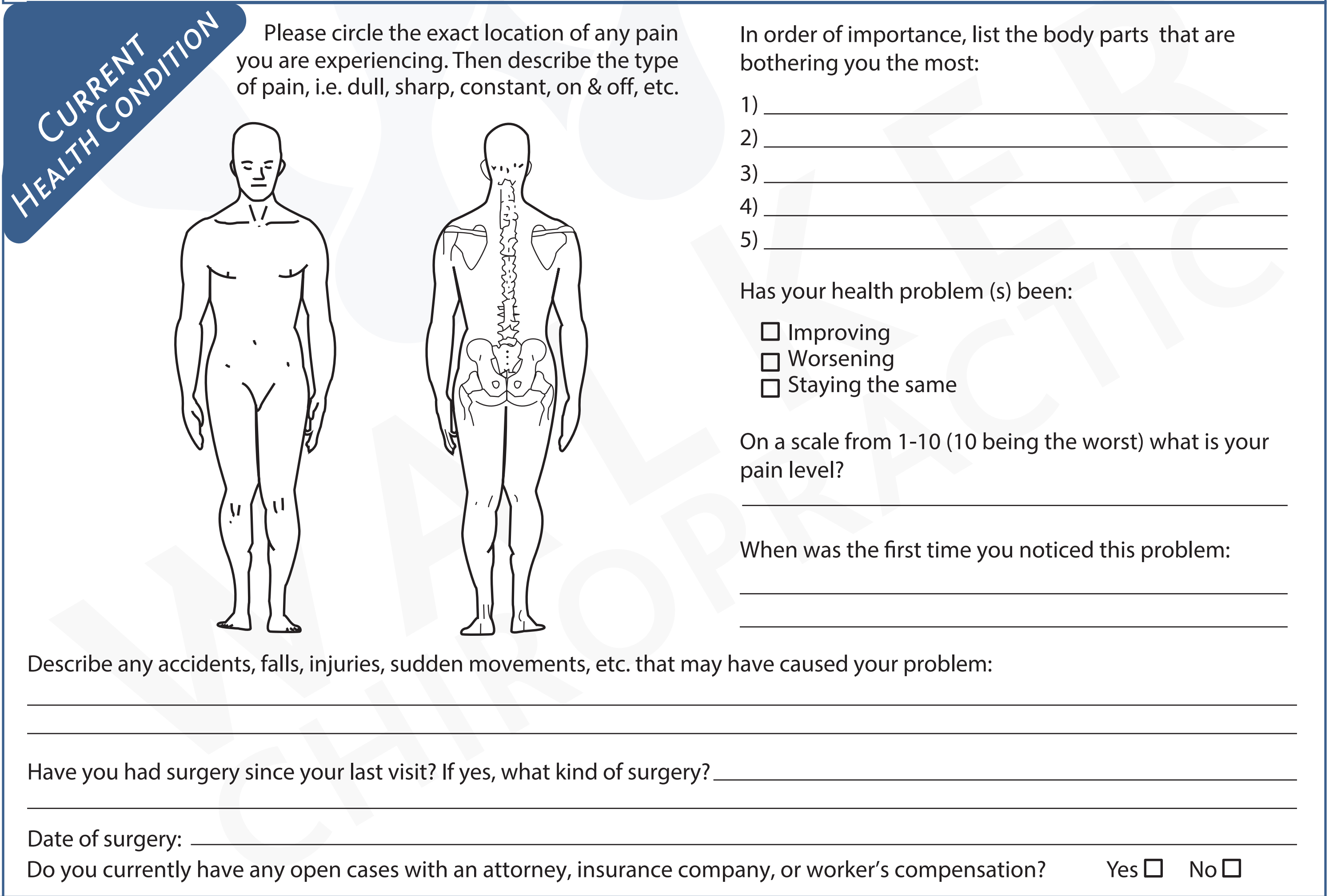
Employer's Name & Address: ______________________

Occupation: ________ Work Phone #: ________ Cell Phone #: ________ Home Phone #: ________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Current Health Condition

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the body parts that are bothering you the most:

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

Has your health problem (s) been:

☐ Improving
☐ Worsening
☐ Staying the same

On a scale from 1-10 (10 being the worst) what is your pain level?

____

When was the first time you noticed this problem:

____
____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem:

____
____

Have you had surgery since your last visit? If yes, what kind of surgery? ______________________

____

Date of surgery: ______________________

Do you currently have any open cases with an attorney, insurance company, or worker's compensation? Yes ☐ No ☐

Has your insurance changed? Yes ☐ No ☐

Insurance Company: ______________________

Insured's Name: ______________________ Relationship: ________ Date of Birth: ___/___/___

Insured's Employer: ______________________

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic and can be formatted to a disc for a fee of $25.

I, the undersigned, hereby give permission for treatment.

Patient's Signature ______________________ Date: ___/___/___

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ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

____ACTIVITIES:	EFFECT:			
☐ Carry Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Lift Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Shower	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Shave	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Extended Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Walk	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Sweep /Vacuum	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Dress	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
☐ Other: ____________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take:

____

____

____

Patient Signature:______________________________________ Today's Date: ___/___/___

Continued on next page

WALKER
CHIROPRACTIC

REVIEW OF SYSTEMS

Please mark **P** for in the Past, **C** for Currently have, or **N** for Never

_______ Headache

_______ Neck Pain

_______ Jaw Pain, TMJ

_______ Shoulder Pain

_______ Upper Back Pain

_______ Mid Back Pain

_______ Low Back Pain

_______ Hip Pain

_______ Back Curvature

_______ Scoliosis

_______ Numb/Tingling arms, hands, fingers

_______ Numb/Tingling legs, feet, toes

_______ Pregnant (Now)

_______ Frequent Colds/Flu

_______ Convulsions/Epilepsy

_______ Tremors

_______ Chest Pain

_______ Pain w/Cough/Sneeze

_______ Foot or Knee Problems

_______ Sinus/Drainage Problem

_______ Swollen/Painful Joints

_______ Skin Problems

_______ ADD/ADHD

_______ Allergies

_______ Dizziness

_______ Loss of Balance

_______ Fainting

_______ Double Vision

_______ Blurred Vision

_______ Ringing in Ears

_______ Hearing Loss

_______ Depression

_______ Irritable

_______ Mood Changes

_______ Eating Disorder

_______ Trouble Sleeping

_______ Prostate Problems

_______ Impotence/Sexual Dysfun.

_______ Digestive Problems

_______ Colon Trouble

_______ Diarrhea/Constipation

_______ Menopausal Problem

_______ PMS

_______ Bed Wetting

_______ Learning Disability

_______ Liver Trouble

_______ Hepatitis (A, B, C)

_______ Ulcers

_______ Heartburn

_______ Heart Problems

_______ High Blood Pressure

_______ Low Blood Pressure

_______ Asthma

_______ Difficulty Breathing

_______ Lung Problems

_______ Kidney Trouble

_______ Gall Bladder Trouble

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Dr. Chris J. Walker, Chiropractor

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name ______________________________ Date ____________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

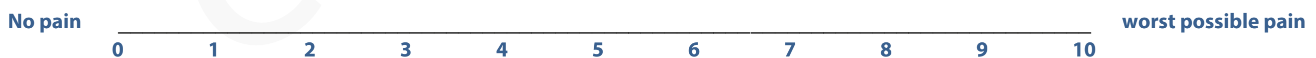
Headache Neck Low Back

1 – What is your pain RIGHT NOW?

2 – What is your TYPICAL or AVERAGE pain?

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

____

____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

Patient Name: ____ **SSN:** ________________

Date of Birth: _____/_____/______ **E-mail Address:** _______________________________________

I______________________________, hereby authorize and request _____________________ ____to release my health information (PHI) to:

Walker Chiropractic
104 Woodland Rd
Augusta, GA 30907
Phone: 706-504-3511 Fax: 706-755-2978

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):

Name ____ Relationship ____________________

Name ____ Relationship ____________________

Name ____ Relationship ____________________

I understand that I am entitled to a copy of Walker Chiropractic's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.augustachiro.com or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

____

Signature of Patient Date