Eastside Chiropractic, P.C.

1011 Woodridge Lane, Building 301

Watkinsville, Georgia 30677

Dr. Bryan Hooper

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. (Please Print)

Name_____ Date_____

Address_____City_____State_____ Zip_____

Sex: ☐ Female ☐ Male Date of Birth_____

Email_____

Home (_____)_____ Cell (_____)_____ Cell phone carrier: _____

Preferred # to receive calls/reminders: _____ Home _____ Cell _____

Patient Employer/School_____ Occupation_____

Employer/School Adress_____City_____ State_____ Zip_____

Spouse or Parents Name_____Employer_____ Work Phone_____

Whom may we thank for referring you to us:_____

Person to contact in case of emergency:_____Relationship to Patient: _____Phone: (_____)_____

Responsible Party

Name of person responsible for this account_____

Relationship to patient:_____ Phone (_____)_____

Address_____City_____State_____Zip_____

Name of Employer_____ Phone (_____)_____

Insurance Information (Please present your card to office staff)

Name of Insured: _____Relationship to patient: _____

Insurance Co_____Phone_____Member ID#_____

Insurance Co Address_____City_____ State_____ Zip_____

Symptoms

Reason for visit:_____

When did you first notice the symptoms?_____

Is this condition getting progressively worse? _____

Where is the problem(s) located? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

☐ Other:_____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Stiffness ☐ Swelling

Other:_____

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

Is the pain constant or does it come or go? _____

Pain is relieved by: _____

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Massage

Name and contact information of other doctors who have treated you for your condition:_____

_____

Daily Habits

What type of exercise do you perform daily? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work?)

_____

_____

What vitamins do you currently take?_____

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

_____

Do you smoke? ☐ Yes ☐ No How much per day?

_____

How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume daily? _____

Health History

Check only those conditions which apply

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergy shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Mental Health Problems
- ☐ Methamphetamine Use/Exposure
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Surgeries
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growth
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other_____

_____

_____

Date of last physical exam_____

Women Only: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

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

_____

Please list all medications you are currently taking:_____

_____

Allergies: _____

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. Bryan Hooper, Eastside Chiropractic, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date