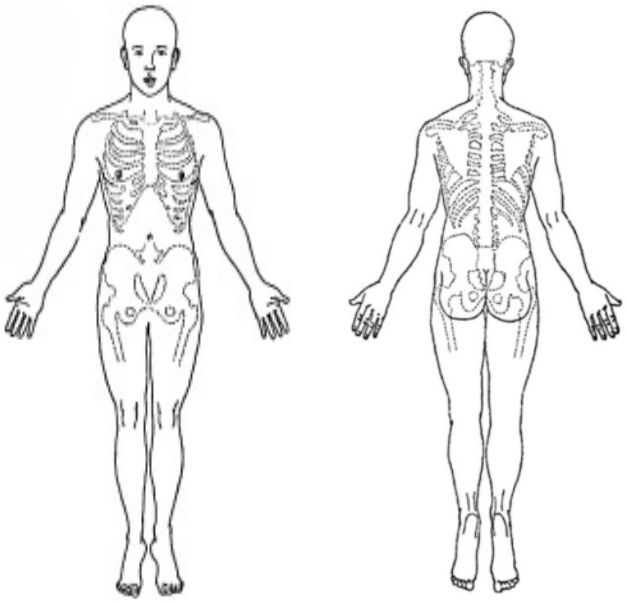
Name (Please Print)_____ Date____/____/____

COMPLETE THESE DIAGRAMS MARKING AREAS OF PAIN



Please list your areas of pain and then rate your pain.

Zero=No Pain 0 1 2 3 4 5 6 7 8 9 10 10 **=Unbearable**

1. _____Rate 0-10 ____

Onset Date/Describe_____

_____

_____

_____

2. _____Rate 0-10____

Onset Date/Describe_____

_____

_____

3. _____ Rate 0-10____

Onset Date/Describe_____

_____

4. _____ Rate 0-10___

_____

List anything that caused/contributed to your problem(s) _____

_____

Is this new or Have you ever had these issues before? Yes _____ No _____ if yes, please explain

_____

Have you been treated for this before by anyone: ☐NO ☐ Yes Who? _____

Problem 1: _____

Please describe the character of your current discomfort (YOU MAY CHECK MORE THAN ONE RESPONSE):

☐ Sharp/Stabbing ☐Shooting ☐Ache ☐Dull ☐Soreness ☐Stiffness ☐Weakness ☐Throbbing/Gnawing ☐Numbness/tingling ☐Burning ☐Gripping/Constricting Grabbing ☐Cramping/Spasm

How often present? ☐ Constant (75% or more of the time), ☐Frequent (51-75%) ☐Occasional (26-50%) ☐ Intermittent (25% or less)

Problem 2: _____

☐ Sharp/Stabbing ☐Shooting ☐Ache ☐Dull ☐Soreness ☐Stiffness ☐Weakness ☐Throbbing/Gnawing ☐Numbness/tingling ☐Burning ☐Gripping/Constricting Grabbing ☐Cramping/Spasm

How often present? ☐ Constant (75% or more of the time), ☐Frequent (51-75%) ☐Occasional (26-50%) ☐ Intermittent (25% or less)

Problem 3: _____ Please describe the character of your current discomfort

☐ Sharp/Stabbing ☐Shooting ☐Ache ☐Dull ☐Soreness ☐Stiffness ☐Weakness ☐Throbbing/Gnawing ☐Numbness/tingling ☐Burning ☐Gripping/Constricting Grabbing ☐Cramping/Spasm

How often present? ☐ Constant (75% or more of the time), ☐Frequent (51-75%) ☐Occasional (26-50%) ☐ Intermittent (25% or less)

211C Bobby Jones Expy, Martinez, GA 30907 Tel: (706) 860-3355 Fax: (706) 860-8765

Please list your primary care doctor first, then other doctors and health conditions:

Dr Name:	**Specialty?**	**Dr Name:**	**Specialty?**
_____	_____	_____	_____
_____	_____	_____	_____

****IF YOU CARRY A LIST OF MEDICATIONS PLEASE PROVIDE A COPY AND DO NOT COMPLETE BELOW****

Medications you take:	**For what condition?**	**Medications you take:**	**For what condition?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any Medication Allergies? YES / NO (If yes please list below)

Medication Name:	**Reaction?**	**Medication Name:**	**Reaction?**
_____	_____	_____	_____

Has any member of your family experienced back or neck pain/stiffness, or been treated for a similar condition?

Relationship to Patient	Describe Condition
1.	
2.	

Family History	Age	Health problems or cause of death
Mother		
Father		
Mother's mother		
Mother's father		
Father's mother		
Father's father		
Brothers		
Sisters		
Children		

Chronic Illnesses _____

_____

Please describe and include dates of Surgery/ Hospitalization/ Operations: _____

_____

Auto Accidents/Fractures/Injuries(Ever): _____

_____

Any Falls in the Last Year:_____

Smoking Status (Circle one): ☐ Never-Smoked ☐ Everyday-Smoke ☐Occasional Smoke ☐ Former-Smoker

HABITS: Sleep (# of hours): _____ ☐ Trouble falling asleep? ☐ Pain wakes you ☐Trouble sleeping for other reasons
Do you feel stiff in the morning? ☐ Yes I sleep on my ☐ Back ☐Side ☐ Stomach ☐ use more than one pillow
How would you grade your general stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

Physical Activity Level at Work: ☐ Sit 50% or more of the day ☐Light Manual labor ☐General labor ☐ Heavy labor

General Physical Activity: ☐No Regular Exercise ☐ Light Routine Exercise ☐ Strenuous Routine Exercise

Hobbies – List _____

I state that the information on all pages of this form is true and correct. I authorize Action Medical Center to examine, make x-rays, treat me and do whatever is deemed necessary in accordance with the state statutes, for the care and management of my condition.

_____

Patient Signature ***Date***

211C Bobby Jones Expy, Martinez, GA 30907 Tel: (706) 860-3355 Fax: (706) 860-8765

Action Medical Center — Patient Demographics

First Name_____ **Middle** _____ **Last** _____ **Suffix** _____

Nick Name_____ **SSN** _____-_____-_____ **Date of Birth** _____/_____/_____

Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

Address _____ **City**_____ **State** _____ **Zip** _____

Home Phone_____ **Cell**_____**Work Phone** _____

Email:_____

Preferred contact method of communication for Appointment REMINDERS (Circle One): TEXT / EMAIL / Phone Call

Emergency Contact Person: _____ **Their Phone** _____

Employment Status *(check one)* ❑ Employed ❑ Retired ❑ Self Employed ❑ Other ❑ FT Student ❑ PT Student

Your Employer _____ **Occupation** _____

Employer's Address_____ **City**_____ **State** _____ **Zip**_____

If you are not the insured policy holder, Please complete the information on the policy holder.

Name of Insured/Policy Holder_____ **Date of Birth:** _____/_____/_____

Address_____ **Phone #:**_____

Employer: _____ **Relationship to Patient:** _____

If patient is a minor, please complete:
Your Name _____ **Relationship to minor** _____

How did you hear about our office? **Please be specific. This information is very important.**

_____

_____

I state that the information on all pages of this form is true and correct. I authorize Action Medical Center to examine, x-ray, treat me and do whatever is deemed necessary in accordance with the state statutes, for the management of my condition.

Patient Signature: _____**Date:**_____

Date:_____ File # _____

If you have ever had an issue below in the past, please check the PAST column.
If you are presently troubled by a particular symptom, check the PRESENT column.
Never had these symptoms, leave BLANK

☐ YES Currently Pregnant?
☐ YES Any History of Cancer?
☐ YES Abnormal Weight ☐ Gain ☐ Loss

PAST	PRESENT	
☐	☐	Tobacco Use ☐light ☐moderate ☐heavy
☐	☐	Alcohol Use ☐light ☐moderate ☐heavy
☐	☐	History of Drug or Alcohol abuse
☐	☐	Coffee/Tea/Caffeinated Drinks (# per day _____)
☐	☐	Headache ☐ Migraine ☐ Tension ☐ Allergy
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Pain in Upper Arm/Elbow
☐	☐	Hand Pain
☐	☐	Upper Back Pain
☐	☐	Lower Back Pain
☐	☐	Upper Leg/Hip Pain
☐	☐	Lower Leg/Knee Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Fainting/Nausea
☐	☐	Loss of Balance/ falls
☐	☐	Tinnitus (Ear Ringing)
☐	☐	Chronic General Body Pain
☐	☐	Arthritis
☐	☐	Total Joint Replacement Area : _____
☐	☐	Pace Maker/ Defibrillator
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Rapid Heart Beat
☐	☐	Aneurysm
☐	☐	Chest Pains / Angina
☐	☐	Reflux/ GERD/ Heartburn/Indigestion

PAST	PRESENT	
☐	☐	Diabetes ☐ Insulin Pump
☐	☐	High Blood Pressure// hypertension (Check **YES** if on medication)
☐	☐	Osteoporosis/Osteopenia
☐	☐	Vitamin D deficiency
☐	☐	Pain stimulator implant
☐	☐	Depression
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Allergies
☐	☐	Dermatitis/Rash/Eczema
☐	☐	Kidney Disease
☐	☐	Blood Disorder
☐	☐	Prostate Problems
☐	☐	Loss of Bladder Control
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Constipation/Irregular Bowel
☐	☐	Convulsions/Seizures
☐	☐	HIV/AIDS
☐	☐	Any Other_____

B12 deficiency signs

☐	☐	pins/needles sensation in hands or feet
☐	☐	Dizziness/ light-headedness
☐	☐	fatigue
☐	☐	weakness, tiredness
☐	☐	pale skin
☐	☐	irritability
☐	☐	constipation / diarrhea
☐	☐	feeling foggy
☐	☐	forgetfulness

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
    - A text or e-mail sent to the mobile number or e-mail address provided by me
    - Telephoning my home and leaving a message on my voicemail or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that if I revoke this consent, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name (PRINT) Name (SIGN)

_____ _____

Signature of Guardian for Minor Relationship

Date Signed _____/_____/_____ Witness: _____

Action Medical Center Financial Policy and Medical Release

*****PLEASE READ and INITIAL EACH LINE BELOW*****

_____ • I understand that Action Medical Center will prepare any necessary reports and forms to assist in collecting from the insurance company.

_____ • I authorize Action Medical Center to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for payment of charges incurred by me as a result of professional services rendered. I hereby release Action Medical Center of any consequence thereof.

_____ • Any amount paid by the insurance company directly to Action Medical Center will be credited to my account. However, I understand that all unpaid services rendered to me are charged directly to me and I am responsible for payment.

_____ • I hereby authorize and direct payment of any medical expense benefits allowable to the doctor named above as payment toward the total charges for professional services rendered.

_____ • We will attempt to collect from your insurance company until all of our efforts have been exhausted. If your insurance has not paid within 120 days, collection efforts will cease and you (the patient) will be billed for the amount the insurance has not paid.

*****I agree that a Photostat copy of this agreement shall serve as the original*****

If you wish to allow our office to release information or records pertaining to your medical condition and care, please list the authorized parties below:

Name of Authorized Party	**Relationship to Patient**

If you would like a report sent to your primary care physician regarding your medical condition and care, please list the first and last name of your doctor and phone number if available. Please check **YES** or **NO**.

Name of Doctor	**Phone Number**

_____**YES,** I would like a report sent to my doctor.

_____**NO,** I would not like a report sent to my doctor.

****Patient Signature**** **Witness** **Date**

NECK INDEX includes: UPPER BACK and ARMS

Patient Name_____ **Date**_____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in on section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

(0) I have no pain at the moment
(1) The pain is very mild at the moment.
(2) The pain comes and goes and is moderate
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worst imaginable at the moment.

Sleeping

(0) I have no trouble sleeping.
(1) My sleep is slightly disturbed (less than 1 hour sleepless).
(2) My sleep is mildly disturbed (1-2 hours sleepless).
(3) My sleep is moderately disturbed (2-3 hours sleepless).
(4) My sleep is greatly disturbed (3-5 hours sleepless).
(5) My sleep is completely disturbed (5-7 hours sleepless).

Reading

(0) I can read as much as I want with no neck pain.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as a I want with moderate neck pain.
(3) I can't read as much as I'd like because of neck pain.
(4) I can only read a little because of severe neck pain.
(5) I can't read at all because of the neck pain.

Concentration

(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully with slight difficulty.
(2) I have a fairly difficult time concentrating.
(3) I have a lot of difficulty concentrating.
(4) I have great difficulty concentrating.
(5) I cannot concentrate at all.

Work

(0) I can do as much work as I want.
(1) I can only do my usual work but no more.
(2) I can only do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any work at all.
(5) I cannot do any work at all.

Personal Care

(0) I can look after myself normally without causing pain.
(1) I can look after myself but it causes extra pain.
(2) I can look after myself but have to change my way of doing things to not cause pain.
(3) I can look after myself but must go slowly and carefully.
(4) I can look after myself but need some help daily.
(5) I am unable to take care of myself because of pain.

Lifting

(0) I can lift heavy weight without extra pain.
(1) I can lift heavy weights off of the floor but with pain.
(2) I can lift heavy weights but it severely increases the pain.
(3) I can lift heavy weight if carefully positioned (ie.on a table).
(4) I can't lift light weights even when carefully positioned.
(5) I cannot lift or carry anything at all.

Driving/Traveling

(0) I can drive/travel without any neck pain.
(1) I have some neck pain when I drive/travel.
(2) I can't drive/travel longer than 90 minutes due to pain.
(3) I can't drive/travel longer than 30 minutes due to pain.
(4) I avoid driving/traveling due to pain.
(5) Driving/traveling causes severe pain.

Recreation

(0) I can do all recreational activities with no pain.
(1) I can do all recreational activities with pain.
(2) I can do the major but not all recreational activities.
(3) I can do a few usual recreational activities.
(4) I can do very little recreational activities.
(5) I can't do any recreational activities.

Headaches

(0) I have no headaches.
(1) I have 1 headache per month.
(2) I have 2 headaches per month.
(3) I have 1 headache per week.
(4) I have 3 headaches per week.
(5) I have headaches almost daily.

Neck Index Score: ☐

BACK INDEX includes: LOW BACK, HIPS and LEGS

Patient Name_____ **Date**_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in on section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

(0) I have no pain at the moment
(1) The pain is very mild at the moment.
(2) The pain comes and goes and is moderate
(3) The pain is fairly severe at the moment.
(4) The pain comes and goes and is very severe.
(5) The pain is very severe and does not change much.

Sleeping

(0) I have no trouble sleeping.
(1) My sleep is slightly disturbed (less than 1 hour sleepless).
(2) My sleep is mildly disturbed (1-2 hours sleepless).
(3) My sleep is moderately disturbed (2-3 hours sleepless).
(4) My sleep is greatly disturbed (3-5 hours sleepless).
(5) My sleep is completely disturbed (5-7 hours sleepless).

Sitting

(0) I can as long as I like with no back pain.
(1) I can only sit in my favorite chair as long as I like.
(2) I can sit for 1 hour before having pain.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) I can't sit at all due to pain.

Standing

(0) I can stand as long as I want without pain.
(1) I have pain while standing but doesn't increase with time.
(2) I can stand for 60 minutes without pain.
(3) I can stand for 30 minutes without pain.
(4) I can stand 10 minutes without pain.
(5) I can't stand at all without having pain.

Work

(0) I can do as much work as I want.
(1) I can only do my usual work but no more.
(2) I can only do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any work at all.
(5) I cannot do any work at all.

Personal Care

(0) I can look after myself normally without causing pain.
(1) I can look after myself but it causes extra pain.
(2) I can look after myself but have to change my way of doing things to not cause pain.
(3) I can look after myself but must go slowly and carefully.
(4) I can look after myself but need some help daily.
(5) I am unable to take care of myself because of pain.

Lifting

(0) I can lift heavy weight without extra pain.
(1) I can lift heavy weights off of the floor but with pain.
(2) I can lift heavy weights but it severely increases the pain.
(3) I can lift heavy weight if carefully positioned (ie.on a table).
(4) I can't lift light weights even when carefully positioned.
(5) I cannot lift or carry anything at all.

Driving/Traveling

(0) I can drive/travel without any back pain.
(1) I have some back pain when I drive/travel.
(2) I can't drive/travel longer than 90 minutes due to pain.
(3) I can't drive/travel longer than 30 minutes due to pain.
(4) I avoid driving/traveling due to pain.
(5) Driving/traveling causes severe pain.

Recreation

(0) I can do all recreational activities with no pain.
(1) I can do all recreational activities with pain.
(2) I can do the major but not all recreational activities.
(3) I can do a few usual recreational activities.
(4) I can do very little recreational activities.
(5) I can't do any recreational activities.

Walking

(0) I have no pain while walking.
(1) I have some pain while walking but doesn't increase with distance.
(2) I can't walk more than 1 mile without pain.
(3) I can't walk more than ½ mile without pain.
(4) I can't walk more than 1 block without pain.
(5) I can't walk without pain.

Back Index Score: