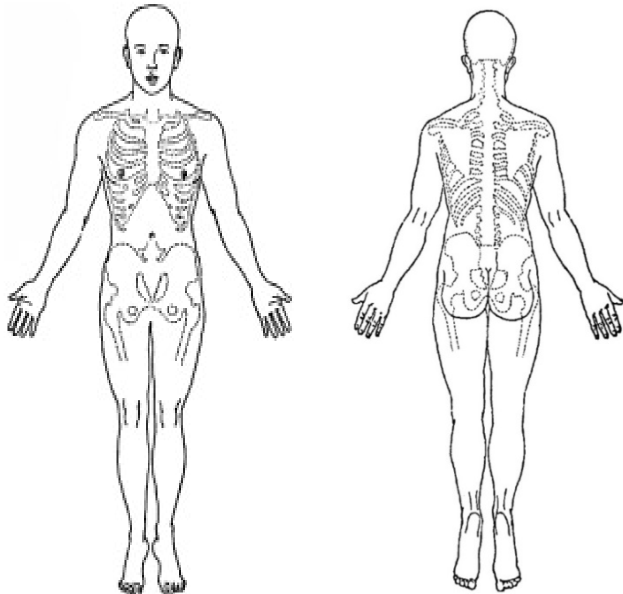
Name (Please Print)____ Date____/____/____

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)

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? **You may check one or more, this information is important to us, thank you**

❑ **Internet search** ❑ **Insurance Website** ❑ **Our Website** ❑ **Youtube** ❑ Word of mouth ❑ **Phone book**

❑ **Newspaper** ❑ **TV** ❑ **Sign/Location** ❑ Massage event ❑ **Lecture** ❑ **Referred by:**_________________________________

❑ **Doctor Referral----Doctor's name** ___________________________ ❑ **Other** ____

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: ____________________________

211 Bobby Jones Expressway Suite C Martinez, GA 30907 706-860-3355

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**

ACTION PHYSICAL THERAPY

Your appointment time with your physical therapist is a 60 minute session set aside just for you.

If you cannot keep this appointment , Action Physical Therapy requires that you notify our office by 5:00pm the day prior to your appointment so this time slot may be given to another patient.

If you fail to notify the office, you will be charged a $25.00 service charge.

_________________________ _________________________

Patient Signature Date

____

Witness