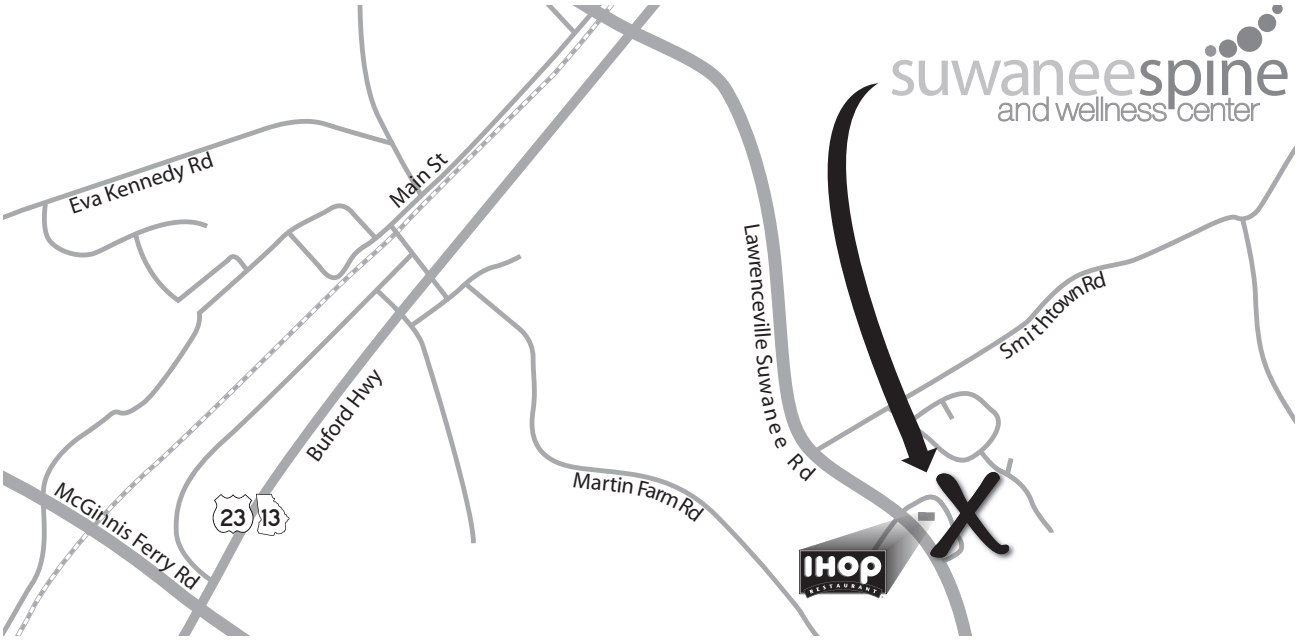
suwaneespine
and wellness center

Congratulations for taking the first step towards a new health journey! Please fill out the attached New Patient paperwork to the best of your ability, being as thorough as possible. The more information you provide, the better we can serve you. Please complete the New Patient paperwork prior to your scheduled appointment time so that we may spend more focused time with you.

We look forward to meeting and serving you!

Our Location…



3449 Lawrenceville-Suwanee Road | Suite F | Suwanee, GA 30024 | 678.765.8494

Directions to our location…

From I-85, take exit 111 - Suwanee. Head West (towards Suwanee) on Lawrenceville-Suwanee Road. After approximately 1.5 miles, turn right into the Georgetowne Square business complex, right behind the IHOP restaurant. Continue straight as it loops behind the IHOP restaurant. Follow the signs for Building 3449, Suite F (end unit).

From Peachtree Industrial Boulevard, take Suwanee Dam Road to Lawrenceville-Suwanee Road. After approximately 2 miles, turn left into the Georgetowne Square business park (first left after Smithtown Road) right behind the IHOP restaurant. Continue straight as it loops behind the IHOP restaurant. Follow the signs for Building 3449, Suite F (end unit).

Personal Health Information

Today's Date: _____/_____/_____

Whom may we thank for referring you to our office?

☐ **Family** _____ ☐ **Friend** _____ ☐ **Co-Worker** _____

☐ **Internet/Website** ☐ **Dr. Millman** ☐ **Dr.** _____ ☐ **Other** _____

Personal Information

Last:_____ **First:**_____ **Middle:** _____

Birth Date: _____/_____/_____ **Age:**_____ **Sex: Male / Female**

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

Spouses Name: _____

Current Address: _____ **Home Phone:** (_____) _____-_____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** (_____) _____-_____

Email Address: _____ **Work Phone:** (_____) _____-_____

**Which method of communication would you prefer:*

☐ **Email** ☐ **Phone Call** (If so, which number: ☐ Cell ☐ Home ☐ Work)

Emergency Contact Information

Last:_____ **First:**_____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** **Home Phone:** (_____) _____-_____

Cell Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Employment Information

Business Name: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** (_____) _____-_____

I hereby acknowledge that the statements made on this form are accurate to the best of my recollection and I knowingly allow ***Suwanee Spine and Wellness Center*** to examine me for further evaluation.

Signature: _____ Date: _____

Current Health Challenge

If you have no symptoms or complaints, and are here for "CHIROPRACTIC WELLNESS SERVICES", check the box here ☐ and move on to the next section, "Lifestyle Review."

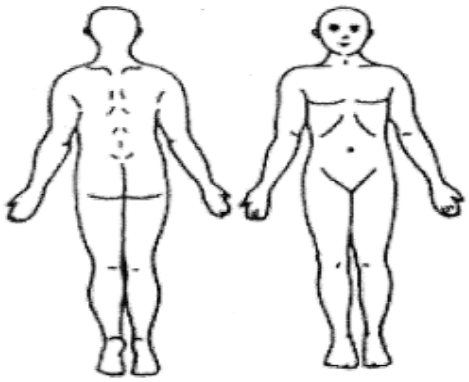
Unwanted Health Challenge (Why you are here today?)

PLEASE LABEL ON THE DIAGRAM THE AREA(s) OF DISCOMFORT

_____

_____

_____



When did this BEGIN? _____/_____/_____

Has it ever occurred before? ☐ **Yes** ☐ **No**

What Makes It Better? _____

What Makes It Worse? _____

Is this related to: ☐ **Auto Accident** ☐ **Job Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Other: Explain: _____

Date of Auto Accident or Work Related Injury: _____/_____/_____

Lifestyle Review

1. Do you believe that it is possible for your body to heal? ☐ **Yes** ☐ **No**

2. What wellness services/products do you currently incorporate into your lifestyle?

_____

_____

3. On a scale of 0-10, describe your stress level: (0= None/10= Extreme)

Occupational:_____

Personal: _____

Please rate the following:

Coffee:	☐ **Heavy**	☐ **Moderate**	☐ **Light**	☐ **None**
General Health:	☐ **Excellent**	☐ **Good**	☐ **Poor**	
Diet:	☐ **Excellent**	☐ **Good**	☐ **Poor**	
Sleep:	☐ **Excellent**	☐ **Good**	☐ **Poor**	
Exercise:	☐ **Heavy**	☐ **Moderate**	☐ **Light**	☐ **None**
Water:	☐ **Heavy**	☐ **Moderate**	☐ **Light**	☐ **None**
Tobacco:	☐ **Do not use**	☐ **Smoke/Chew** _____**/day**	☐ **Live with a smoker**	☐ **Quit smoking**
Alcohol:	☐ **Do not use**	☐ _____ **Drinks/Week**	☐ _____ **Drinks/Month**	

Review Of Systems

Please check the boxes below that apply to you.
Indicate a "**P**" next to the problem if it a Past problem you no longer have.
If none of them apply, please check the " ☐ I DENY " box in the shaded area.

Nervous System: ☐ I DENY having any of the symptoms or problems listed below.

☐ dizziness	☐ strokes	☐ loss of memory	☐ slurred speech	☐ migraines (how often?) _____
☐ seizures	☐ headache	☐ facial weakness	☐ leg weakness	☐ arm/hand weakness
☐ burning	☐ fibromyalgia	☐ sleep disturbance	☐ numbness/tingling	☐ rheumatoid arthritis
☐ tremor	☐ pinched nerve	☐ multiple sclerosis	☐ balance/instability	☐ loss of consciousness

Respiratory System: ☐ I DENY having any of the symptoms or problems listed below.

☐ asthma	☐ wheezing	☐ emphysema/COPD	☐ sputum production
☐ cough	☐ pleurisy	☐ food intolerance	☐ coughing up blood
☐ anaphylaxis	☐ itching	☐ chronic nasal congestion	☐ chemical/fragrance sensitivity
☐ rash	☐ sneezing	☐ acute nasal congestion	

Gastrointestinal/Urinary: ☐ I DENY having any of the symptoms or problems listed below.

☐ belching	☐ constipation	☐ frequent throat clearing	☐ vomiting blood
☐ colitis	☐ diarrhea	☐ abdominal pain	☐ rectal bleeding
☐ heartburn	☐ indigestion	☐ abnormal stool color	☐ difficulty swallowing
☐ nausea	☐ jaundice	☐ abnormal stool consistency	☐ gallbladder trouble
☐ hemorrhoids	☐ vomiting	☐ black, tarry stools	☐ painful/difficult urination

Psychologic: ☐ I DENY having any of the symptoms or problems listed below.

☐ irritability	☐ convulsions	☐ loss or change in appetite	☐ anxiety/depression	☐ memory loss
☐ mood change	☐ confusion	☐ behavioral change	☐ bi-polar disorder	☐ insomnia

Musculoskeletal: ☐ I DENY having any of the symptoms or problems listed below.

☐ degenerative arthritis	☐ bursitis	☐ osteoporosis	☐ TMJ dysfunction	☐ tendonitis	☐ mid back pain
☐ low back pain	☐ neck pain	☐ hip pain	☐ shoulder pain	☐ knee/leg pain	☐ feet pain

Cardiovascular: ☐ I DENY having any of the symptoms or problems listed below.

☐ blood clots	☐ palpitations	☐ angina (chest pain or discomfort)	☐ shortness of breath
☐ ulcers	☐ high blood pressure	☐ orthopnea (difficulty breathing lying down)	☐ swelling of legs
☐ heart murmur	☐ low blood pressure	☐ claudication (leg pain/ache)	☐ varicose veins

Constitutional/Endocrine: ☐ I DENY having any of the symptoms or problems listed below.

☐ chills	☐ fatigue	☐ night sweats	☐ weight loss	☐ cancer: _____
☐ fever	☐ weight gain	☐ daytime drowsiness	☐ diabetes	☐ thyroid problems

Immune System: ☐ I DENY having any of the symptoms or problems: ☐ frequent colds/sickness/flu How often? _____

For Women Only: ☐ I DENY having any of the symptoms or problems listed below.

☐ currently pregnant	☐ menstrual problems/PMS	☐ dysmenorrhea (painful periods)
☐ irregular cycles	☐ difficulty getting pregnant	☐ menopausal problems

Past Health History

Complete carefully as these problems can affect your overall course of care.

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor OR Fill in the information below:**

Chiropractor's Name: _____ Date of Last Visit: _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific. Use reverse side of the paper if necessary.**

_____

_____

Doctor's Name: _____

Allergies: **LIST All known allergies to food/plants/nuts/essential oils.**

_____

_____

Childhood Illness (es): **LIST all health conditions.**

_____

_____

Adult Illness (es): **LIST all health conditions.**

_____

_____

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure.**

_____

_____

Injury (ies): Mark or List All Injuries. Write the DATE next to any checked box.

☐ **back injury _____** ☐ **broken bones _____** ☐ **fall (severe) _____** ☐ **fracture _____**

☐ **Loss of consciousness/How many times? _____** ☐ **head injury _____** ☐ **joint injury**

☐ **Car Accident(s): How many _____ Airbags deploy?_____** ☐ **laceration(s)/cuts: _____**

Use the lines below to describe the details of any above checked box.

_____

_____

Initial Quality of Life Assessment

This form allows us to examine and evaluate your health status as you progress through care. Answer the questions below as it *pertains to only one specific symptom or complaint.* For multiple complaints, use a separate form for each symptom.

1. What is your **primary** health complaint/problem? _____

2. **Secondary**/Additional symptoms (Please use additional questionnaire): _____

_____

3. **Level of Impairment Due to Symptom** (circle the appropriate level with 0 = none / 10 = extreme)

While Resting:	0	1	2	3	4	5	6	7	8	9	10
With Activity:	0	1	2	3	4	5	6	7	8	9	10

4. **Job Performance:** ☐ No Effect ☐ Mild Pain ☐ Moderate Pain ☐ Unable to Perform ☐ N/A

5. **Daily Activities - Effects of Current Complaint on Performance**

Bending	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Carrying items 15 lbs or less	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Changing Position (Sit-Stand)	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Climbing Stairs	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Mental Clarity/Decision Making	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Extended Computer Use	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Physical Activity/Exercise	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Household Chores/Yard Work	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Kneeling/Squatting	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Lifting	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Reading/Concentration	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Self Care (Bathe/Dress/Groom)	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Sleeping	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Ability to get comfortable (sleeping)	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Prolonged Sitting	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Prolonged Standing	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Walking	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)

6. What is your symptom keeping you from doing that you would like to do? _____

_____

7. On a scale from 0-10 (0 = lowest quality, 10 = highest quality), how would you currently rate your overall quality of life? _____

Patient Name: _____ Signature: _____ Date: _____