

SUWANEESPINE

AND HEALING 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!

Please note: ***We have recently moved locations!***

Our new address is: 4300 Westbrook Road, Bldg E, Suwanee, GA 30024

We have had difficulty with our address being recognized by Google maps, etc, despite our best efforts to correct it. Having said that, we have found it most effective to use the Chevron gas station address located just north of our building complex (across the street on Westbrook Road, but on the same side of the road as Buford Highway).

Chevron gas station:
429 Buford Highway
Sugar Hill, GA 30518

Directions to our location:

We are located 2.0 miles north of Suwanee Town Center, at the corner of Buford Highway and Westbrook Road. We are just beyond Roberts Elementary School. If you're traveling north on Buford Highway, our building will be on the right. You'll turn right at the Chevron gas station on Westbrook Road. If you've passed the gas station, you've gone too far. Our building backs directly up to Buford Highway.

When you turn into the complex, we are Building E (the last building at the end).

If you need further assistance, feel free to call us at (678) 765-8494.

Sincerely,

Dr. Lauren Millman

Personal Health Information

Today's Date: ____ □ ____ □ ____

SUWANEESPINE

AND HEALING CENTER

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 Other

Spouses Name: _____

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

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

Email Address: _____

**Which method of communication would you prefer to receive an Appointment Reminder?*

Email: Text Message: Neither

When would you prefer to receive a Text Message Appointment Reminder:

24 hours before appointment 6 hours before appointment 3 hours before appointment 2 hours before appointment

Emergency Contact Information

Last: _____ First: _____

Relationship: Spouse Relative Friend Cell 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 Healing Center* and the practitioners within to examine me for further evaluation.

Signature: _____

Date: _____

Current Health Challenge

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

Unwanted Health Challenge (Why you are here today?)

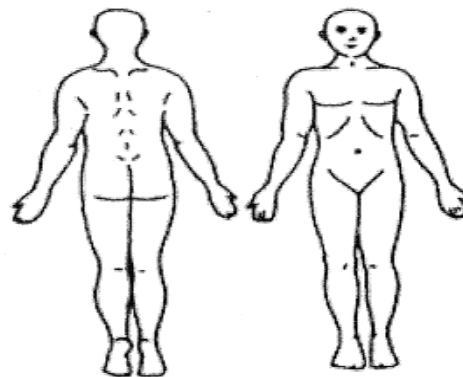
PLEASE LABEL ON THE DIAGRAM THE AREA(S) OF DISCOMFORT

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 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.

- frequent 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 do you tend to get sick? _____

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 all medications you are CURRENTLY taking and for what purpose.
Include the condition for which you are taking it for and for how long you've been taking it.

Doctor's Name: _____

Current Supplements (s): List all supplements you are CURRENTLY taking and for what purpose.

Allergies: LIST All known allergies

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.

Patient Name: _____ Signature: _____ Date: _____

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