Timothy P. Kelly D.C.
3575 Piedmont Road N.E.
15 Piedmont Center, Suite Plaza 130
Atlanta, Ga. 30305.
Phone: 404-477-1589 Fax: 404-477-1590

NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license, Insurance and or Medicare card
PLEASE PRINT CLEARLY

Name: _____ E-mail: _____Gender: M__ F__ Age:___ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Driver's License #: _____ Home Phone: (___) _____ Cell Phone:(__) _____

Fax: (___) _____ Work Status: Full-Time □ Part-Time □ Retired □ Student □ Marital Status: S □ M □ D □ W □

Name of Spouse □, Parent □, or Guardian □: _____ Age: _____ Phone: (___) _____

Children's Names & Ages _____

Emergency Contact: _____Phone:(___) _____Relationship: _____

Employer: _____ Occupation: _____ Work Phone: (___) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Who is responsible for payment? _____ How will payment be made: Cash □ Check □ Credit Card □ Other_____

Insurance Company: _____ Policy Number: _____

Address: _____ Phone: _____

Have you had previous Chiropractic care? yes □ no□ Positive Experience: yes □ no □ _____

Who may we thank for referring you to our office? _____ Insurance □ Internet □ MD Referral □ Other:_____

Who is your primary care physician? _____ Phone: _____Date of last physical/exam? _____

May we update your medical doctor regarding your treatment in our office? yes □ no □

WHAT ARE YOUR COMPLAINTS? Please provide as much detail as possible.

1)_____

2)_____

3)_____

4)_____

How did it originally occur? _____

Has it become worse recently? Yes □ If yes, why: _____ No □ Same □ Better □ Gradually worse □

How often is the condition? Constant □ Daily □ Intermittent □ Night only □ How long does it last? All Day □ Few hours □ Minutes □

Is this condition interfering with your: Work □ Sleep □ Daily routine □ Recreation □ Other: _____?

How long has it been since you felt really good? Days □ Weeks □ Months □ Years □ Over 10 years □

What makes the problem worse? Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting □ Other:_____

Is there anything that you can do to relieve the problem? Yes □ No □ If yes, describe: _____

If no, what have you tried to do that has not helped? _____

What do you believe is wrong with you? _____

Are there any other conditions or symptoms that may be related to your major symptom? Yes □ No □ If yes, what? _____

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition? Yes □ No □

If yes, whom? _____ Treatment(s): _____

Have you had any intolerance or reactions to treatment? Yes □ No □ Describe: _____

Do any family members suffer from the same complaint? If so, who? _____

Have you ever been in an auto accident? Past year □ Past 5 years □ Over 5 years □ Never □ Please Describe: _____

TREATMENT: What type of treatment are you looking for?

□ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.

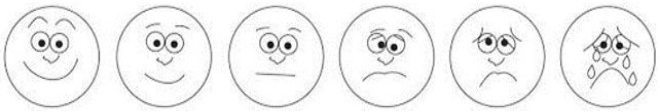
□ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.

□ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

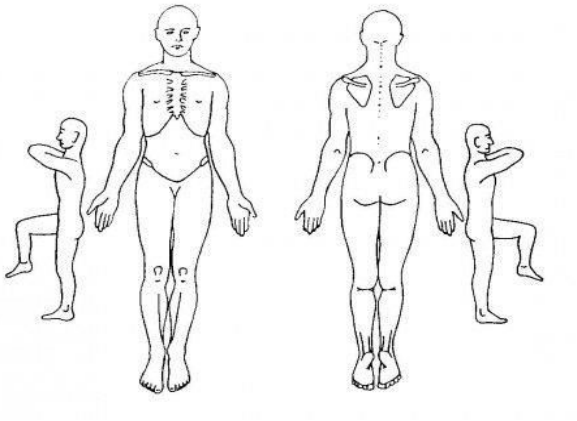
PLEASE CIRCLE - WHAT, WHERE, AND HOW MUCH IT HURTS USE CODES AND AMOUNTS SHOWN BELOW.

AA= ACHE, **NN**= NUMBNESS, **TT**= TINGLING, **SS**=SHARP/STABBING, **SH**= SHOOTING, **SO**= SORENESS, **SW**=SWELLING **XX**=OTHER, PLUS THE PAIN INTENSITY NUMBER (shown below)

EXAMPLE: CIRCLE LOW BACK AND MARK; **AA7, TH5,**
CIRCLE INSIDE RIGHT KNEE AND MARK; **SO4**



Pain 0-1 2-3 4-5 6-7 8-9 10



PLEASE MARK ALL THAT APPLY: (P=Past / **C**=Current**)**

_ _ Headache
_ _ Neck Pain
_ _ Tingling in Hands
_ _ Cold/Clammy Hands
_ _ Shoulder Pain
_ _ Upper Back Pain
_ _ Mid Back Pain
_ _ Low Back Pain
_ _ Hip Pain
_ _ Teeth Grinding
_ _ Dry Mouth
_ _ Excessive Thirst
_ _ Unpleasant Odor
_ _ Face Pain
_ _ Sore Throat
_ _ Lump in Throat
_ _ Swallowing Pain
_ _ Earache
_ _ Eye Pain_ _ Dry
_ _ Sinusitis
_ _ Chest Pressure/Pain
_ _ Slow Heart Rate
_ _ Rapid Heart Rate

_ _ High Blood Pressure
_ _ Low Blood Pressure
_ _ Abdominal Pain
_ _ Nausea/ Vomiting
_ _ Poor Appetite
_ _ Heartburn/Indigestion
_ _ Urination Difficulty
_ _ Frequent Urination
_ _ Constipation
_ _ Hemorrhoids
_ _ Persistent Diarrhea
_ _ Dark or_ _ Blood in Stools
_ _ Elbow / Hand Pain
_ _ Wrist Pain
_ _ Skin Rash
_ _ Sore Muscles
_ _ Knee Pain
_ _ Poor Circulation
_ _ Swollen Joints
_ _ Joint Stiffness
_ _ Swollen Ankles
_ _ Ankle / Foot Pain
_ _ Walking Problems

_ _Dizzy Standing Up
_ _ Fatigue
_ _ Confusion
_ _ Weak Muscles
_ _ Paralysis
_ _ Shakiness
_ _ Sweating _ _at Night
_ _ Insomnia
_ _ Wake at 2 AM for 1 Hour
_ _ Convulsions
_ _ Irritability
_ _ Impatience
_ _ Forgetfulness
_ _ Feel Loss of Control
_ _ Hair Loss
_ _ Weight Loss of 10 lbs or More
_ _ Difficulty Losing Weight
_ _ Loss of Appetite
_ _ Crave; Sweets Carbs Salty Fats
_ _ Bruise Easily
_ _ Persistent or Unusual Cough
_ _ Fainting
_ _ Decreased Sex Drive

Females-Mark if you have the following:
Is there a possibility you are pregnant? Yes ☐ No ☐
Date of Last Menstrual Cycle: _____
☐ Back pain with menstrual periods
☐ Menstrual Irregularities
☐ Abnormal Pap smear within last two years
☐ Vaginal bleeding other than period
☐ Other menstrual problems: _____
_____

Do you have current problems with:
☐ Anxiety
☐ Depression
☐ Unusual stress at home
☐ Unusual stress at work
☐ _____

Are you concerned about:
☐ Dyslexia
☐ Attention Deficit Disorder
☐ Learning Difficulty- Subjects; _____
☐ Motor/ Coordination Difficulty_____
☐ Speech Difficulty_____
☐ Autism
☐ Asperger's

ALLERGIES: Food: _____
Medication: _____
Seasonal / Other: _____

SURGERY/SCARS: _____

VITAMINS AND SUPPLEMENTS: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	**Date Started**
Antacids		
Antibiotics		
Antidepressants		
Anti-Diabetics		
Anti-Inflammatory		
Blood Pressure Lowering Meds		
Cholesterol Lowering Meds		
Hormone Replacement (HRT)		
Oral Contraceptives		
Other		

YOUR HEALTH HISTORY - Please CIRCLE all that apply:

☐ AIDS/ HIV
☐ Allergy Shots
☐ Anemia
☐Anorexia
☐Appendicitis
☐Arthritis
☐Asthma
☐Bleeding
☐Breast Lump
☐ Bronchitis
☐Bulimia
☐Cancer
☐Cataracts
☐Chicken pox
☐Depression
☐Diabetes
☐Emphysema
☐Epilepsy
☐Fractures
☐Glaucoma
☐Goiter
☐Gonorrhea
☐Gout
☐Heart dx
☐Hepatitis
☐Hernia
☐Herniated disc
☐Herpes
☐High Cholesterol
☐Kidney dx
☐Liver dx
☐Measles
☐Migraines
☐Miscarriage
☐Mono
☐M. S.
☐Mumps
☐Osteoporosis
☐Parkinson's
☐Polio
☐Pacemaker
☐Pneumonia
☐Prostate
☐Prosthesis
☐Implants
☐Rheumatoid
☐Stroke
☐Thyroid
☐Tonsillitis
☐Tuberculosis
☐Tumors
☐ Metal Fillings
☐ Root Canal__
☐Typhoid
☐Ulcers
☐V. D.
☐Whooping
☐Cough
☐Chronic
☐Fatigue
☐High Blood
☐Pressure
☐Fibromyalgia

YOUR FAMILY HEALTH HISTORY: Identify any condition that you or any of your family members have now or have had in the past:
(**G=**Grandparents, **M=**Mother, **F=**Father, **S**= Siblings,)

____ Alcoholism
____ Anemia
____ Cancer
____ Cold Sores
____ Deep vein thrombosis
____ Detached Retina
____ Diabetes
____ Eczema
____ Emphysema
____ Epilepsy
____ Goiter
____ Gout
____ Heart Disease
____ HIV / AIDS
____ Miscarriage
____ Mumps
____ Pleurisy
____ Pneumonia
____ Polio
____ Rheumatic Fever
____ Stroke
____ Tumor
____ Ulcer
Other:_____

HABITS:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
None				
Coffee	☐	☐	☐	☐
Soda/Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

Exercise: ☐ 5 -7x/wk. ☐ 3-5x/wk. ☐1-3x/wk. Type: _____Time: _____☐

Sleep: ☐ 8+ hrs. ☐ 7-8 hrs. ☐ 6-7 hrs. ☐ 5-6 hrs. ☐ <5 hrs.

Meals / Day: ☐ 5+ ☐ 4 ☐ 3 ☐ 2 ☐ 1

Water / Day: ☐ 64+ oz. ☐ 32-64 oz. ☐ 16-32 oz. ☐ <8oz.

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
Patient's Signature Date

Timothy P. Kelly, D.C., Buckhead Wellness Center PH 404-477-1589 FAX 404-477-1589
3575 Piedmont Rd. N.E., 15 Piedmont Center, Suite P 130 Atlanta, Ga. 30305

Patient Consent for Use and Disclosure of Protected Health Information

- *This form is necessitated by HIPAA Federal Privacy Regulations.*
- I hereby give consent to Timothy P. Kelly, D.C. and the staff of Buckhead Wellness Center (The Office), to use and disclose protected health information (P.H.I.) about me to and to carry out Treatment, and obtain Payment, and perform healthcare Operations (T.P.O.).
  The Office Notice of Privacy Practices provides a more complete description of such uses and disclosures**.**
- I have the right to review the Notice of Privacy Practices prior to signing this consent. The Office reserves the right to revise its Notice of Privacy Practices at any time. A revised and current Notice of Privacy Practices may be obtained by forwarding a written request to:
- Timothy P. Kelly, D.C.3575 Piedmont Rd. N.E., 15 Piedmont Center, Suite Plaza 130 Atlanta, Georgia 30305
- With this consent, The Office may contact my home or alternate locations and with an email, text, leave a message on voice mail or in person in reference to any items that assist the practice in carrying out T.P.O., such as insurance inquiries, appointment reminders, financial statements, missed appointment notification, birthday or holiday cards, information about treatment alternatives or other health related information.
- I have the right to request, in writing, that The Office restrict how it uses my P.H.I. to carry out T.P.O. However, the practice is not required to agree to my requested restrictions, but if it does agree, it is bound by this agreement. By signing this agreement, I am consenting to The Office the use and disclosure of my P.H.I. to carry out T.P.O.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Office may decline to provide treatment to me.

Consent to Treat a Minor: I hereby authorize the doctor and/or staff of Buckhead Wellness, to tender any form of treatment of Chiropractic as permitted by law and which in their sole discretion would benefit my minor child.

_____

Pregnancy Declaration:

I verify that my last menstrual period was _____ and that I am not pregnant. The doctor and/or staff have been informed of my condition and are not responsible for any problems as a result of diagnostic x-rays taken.

Payment Policy:

We accept cash, check, Visa, MasterCard, American Express, and Discover. Payment is due at time of service, unless a payment arrangement is made with the office manager. If insurance is being filed, co-pays and any deductibles are due at time of service.

Assignment of Payment:

I hereby authorize and direct my insurance company and/or attorney to pay the doctor directly any monies due him on my account. I hereby, further, give a lien on my case to said doctor against any and all proceeds of my settlement as the result of the injuries for which I am treated. This payment shall be made first before all other payment obligations.

I fully understand that I am directly and fully responsible for all medical bills for services rendered to me, and this agreement is made solely for said doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I have read and understood how my Patient Health Information will be used and I agree to the policies and procedures of this office.

Name of Patient: _____ Date _____

Signature of Patient/ Guardian_____

Print Name & Relationship to Patient: _____