

*W*elcome to the Buckhead Wellness Center

Your first visit to the Buckhead Wellness Center will be an opportunity for us to learn about you and your health concerns. We believe it is important for you to have the time to interview us as well. We view this first interaction as a time in which we will become better acquainted.

At Buckhead Wellness Center, it is our mission to serve every person with respect, honesty, and compassion. We will also strive to provide an exceptional healing experience from which you can achieve all of your health and wellness goals. The precision of our chiropractic adjustments facilitate the body's magnificent innate ability to heal, repair and re-balance itself. The result is relief from pain and other unwanted symptoms, fixing the underlying cause of these problems and optimizing your health and well – being.

The information you provide on following pages is vital for us to determine if we can accept your case. Much of this information will be discussed in our first meeting. The more detailed information you can provide, the better we can serve you completely. Our purpose is to make you feel comfortable through this process. We will keep you informed every step of the way to insure that your experience is an enjoyable one.

With You in Mind,

**Dr. Christopher Scoma
Buckhead Wellness Center**



Christopher Scoma, DC3098 Piedmont Rd., NE Suite 430, Atlanta GA. 30305
Phone: 404-477-1589 Fax: 404-477-1590**NEW PATIENT INFORMATION****Welcome!** Thank you for choosing our office to serve your healthcare needs.**PLEASE PRINT CLEARLY****Full Name:** _____ **Gender:** M F **Age:** ____ **Birth Date** _____**Address:** _____ **Apt#:** _____**City:** _____ **State:** _____ **Zip:** _____**Home Phone:** _____ **Work:** _____ **Cell:** _____**Email:** _____**Social Security Number:** _____ - _____ - _____**Marital Status:** S M D W **# of Children:** _____ **Work Status:** Full-time Part-time Retired**Employer:** _____ **Occupation:** _____**Employer Full Address:** _____**Name of Spouse, Parent or Guardian:** _____ **Age:** ____ **Birth Date:** _____**Social Security Number** _____ - _____ - _____ **Work Phone:** _____ **Cell:** _____**Employer:** _____ **Occupation:** _____**In case of Emergency Contact:** _____ **Relationship:** _____**Home Phone:** _____ **Work:** _____ **Cell:** _____**Insurance Company** _____ **Policy #:** _____ **Group#:** _____**Do you have Medicare Insurance?** Y N**Please allow our staff to photocopy your :** Driver's License Insurance Medicare cards.**How did you hear about us? Who may we thank for referring you to us?** _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations (3103) THE PATIENT IDENTIFIED ABOVE AUTHORIZES BUCKHEAD WELLNESS CENTER (BWC) AND CHRISTOPHER D. SCOMA, DC, PC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to BWC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information. If BWC contacts me by phone at home, work or on my cell phone, I give permission the office staff to leave a phone message on my answering machine or voice mail I give BWC permission to treat me in an open room where other patients may also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I ask to speak with the doctor at any time in private, the doctor will provide a room for these conversations. I understand that I may choose treatment in a private room rather than in the open adjusting suite. I give permission BWC to speak to me about treatment or report of findings in front of my spouse or children if I choose to bring them to my appointments. I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. By signing this form, you are giving BWC permission to use and disclose your protected health information in accordance with the directives listed above.

I have read and understand how my Patient Health Information will be used and I agree to the policies and procedures of this office.**Patient/Guardian Signature:** _____ **Date:** _____**Printed Name:** _____ **Relation to Patient:** _____

PLEASE PRINT CLEARLY

Date: _____

Patient Name: _____ Birth Date: _____ Soc. Sec. #: _____

Insurance Company: _____ Policy Number: _____

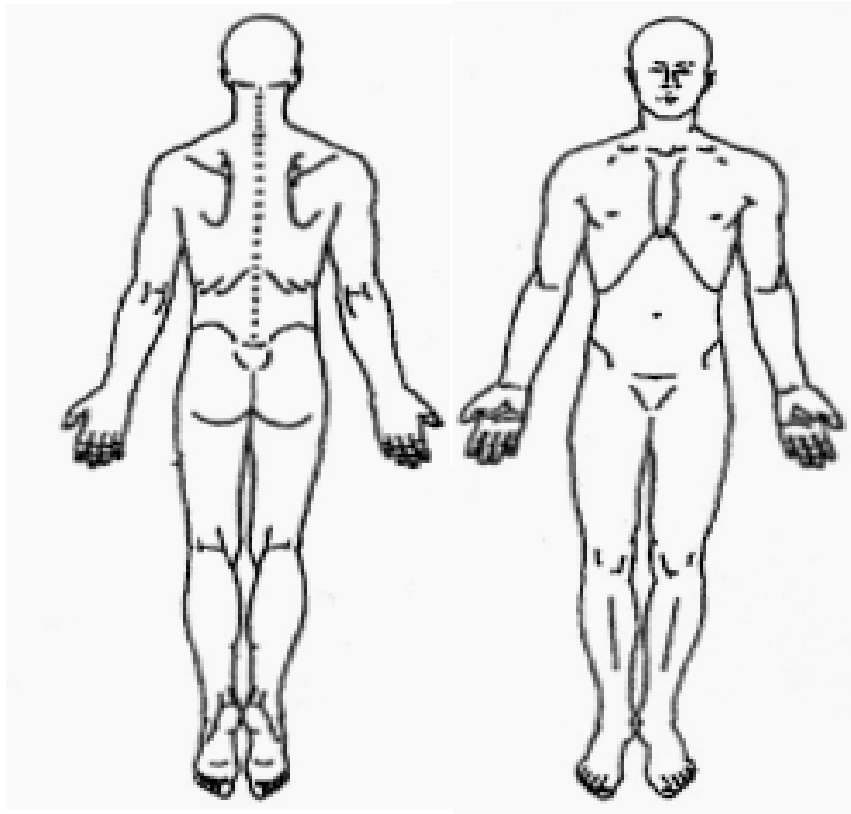
CURRENT HEALTH CONCERNS: Please list your top health concerns in order of priority. If you are not experiencing any health complaints at this time and are seeking Prevention and Wellness Care, skip to the Health History portion of this document.

On what date did these symptoms begin? _____

What do you believe is the cause of your symptoms? Accident? Injury? or something gradual over time?

Please mark the diagram with one or more of the following symbols to indicate the area you are feeling that sensation.

- SP = Sharp Pain DA = Dull Ache BN = Burning TH = Throbbing
- ST = Stiff RA = Radiating NU = Numbness TI = Tingling SC = Scars



How would you rate the intensity of your symptoms?
(0-10 scale; where 0 = nothing - 10 = severe)

0 1 2 3 4 5 6 7 8 9 10

How often are these symptoms present?

- Constant (81-100)
- Frequent (51-80%)
- Occasional (25-50%)
- Intermittent (25% or less)

How long do your symptoms last?

- All day Few hours Minutes

How are your symptoms changing?

- Improving Not Changing Getting Worse

What makes your symptoms worse?

What makes your symptoms better?

Have you had similar symptoms in the past? Yes No

What have you tried to relieve this symptom? (Rest, Meds, other doctors, physical therapy, massage, herbal remedies etc.)

How much has this problem interfered with work and social activities?

- Not at all A little bit Moderately Quite a bit Extremely

In general, how would you rate your overall health right now?

- Excellent Very Good Good Fair Poor

What is your occupation?

- Professional/Executive White Collar/Secretarial Tradesperson Laborer Homemaker Student Retired Other

If you are not retired, a homemaker, or a student, what is your current work status?

- Full-time Part-time Self-employment Unemployment Off Work Other _____

HEALTH HISTORY: Please mark all that apply to your health history.

Please check all of the symptoms that apply to you. (P = Past / C = Current)

P/C	P/C	P/C	P/C	P/C
<input type="checkbox"/> Headache	<input type="checkbox"/> Facial Pain	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Earache	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Confusion	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Unpleasant Taste	<input type="checkbox"/> Lump in Throat
<input type="checkbox"/> Swallowing Pain	<input type="checkbox"/> Unsteady Voice	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Chest Pressure	<input type="checkbox"/> Slow Heart Rate
<input type="checkbox"/> Rapid Heart Rate	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Fullness of Bladder	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Constipation
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Decreased Sex Drive	<input type="checkbox"/> Menstrual Irregular	<input type="checkbox"/> Tingling in Hands	<input type="checkbox"/> Clammy Hands
<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Joint Stiffness	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Tingling in Feet
<input type="checkbox"/> Sore Muscles	<input type="checkbox"/> Weak Muscles	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Shakiness	<input type="checkbox"/> Excess Sweating
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Fainting	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Irritability	<input type="checkbox"/> Impatience
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Feel Loss of Control	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Arm Elbow Hand Pain
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Lowback Pain	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Leg/Knee Pain	<input type="checkbox"/> Ankle/Foot Pain
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____			

Birth History

- | | | | | |
|--|-------------------------------------|--|---|---|
| <input type="checkbox"/> Hospital Birth | <input type="checkbox"/> Home Birth | <input type="checkbox"/> Long Labor/Delivery | <input type="checkbox"/> Difficult Delivery | <input type="checkbox"/> Induced Labor |
| <input type="checkbox"/> Medication Used | <input type="checkbox"/> Epidural | <input type="checkbox"/> Breach | <input type="checkbox"/> C-Section | <input type="checkbox"/> Forceps/Vacuum |

Growth and Development: Childhood and Adult

- | | | | | | |
|--|---|---|---|---|---|
| <input type="checkbox"/> Multiple Illnesses | <input type="checkbox"/> Surgery | <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Medication | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Breast Fed |
| <input type="checkbox"/> Any Falls | <input type="checkbox"/> Out of Bed | <input type="checkbox"/> Off a Bicycle/ Skateboard etc. | <input type="checkbox"/> Out of a Tree | <input type="checkbox"/> Down Stairs | <input type="checkbox"/> Sports/Athletics |
| <input type="checkbox"/> Accidents | <input type="checkbox"/> Injuries: | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Prolonged Emotional Stress | |
| <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Dental Work | <input type="checkbox"/> Head Banger/Head Rocker | <input type="checkbox"/> Poor/Weak Posture | | |
| <input type="checkbox"/> Active/Push Self Hard | <input type="checkbox"/> Chronic Inactivity | | <input type="checkbox"/> Poor Eating Habits | | |

Current Health Habits:

Heavy	Moderate	Light	None	Exercise Times	5-7	3-5	1-3	None	Type
Smoke/Tabacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

	Heavy	Moderate	Light	None						
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Hours	8+	7-8	6-7	5-6	<5
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	per night:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks/Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meals	5+	4	3	2	1
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	per day:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Surgical Procedures: Please list all surgery _____

Ounces Water	64+	32-64	16-32	8-16	<8
per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Supplements: Do you take vitamin/supplements or herbs? Y N If yes, Who recommended them? _____

Allergies: Please check and list all allergies.

Food: _____

Medications: _____

Seasonal / Other: _____

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

	<u>Medication Name</u>	<u>Date Started</u>
<input type="checkbox"/>	Antacids:	_____
<input type="checkbox"/>	Antibiotics:	_____
<input type="checkbox"/>	Anti-Depressants:	_____
<input type="checkbox"/>	Diabetes:	_____
<input type="checkbox"/>	Anti-Inflammatory:	_____
<input type="checkbox"/>	Pain Killers:	_____
<input type="checkbox"/>	Blood Pressure:	_____
<input type="checkbox"/>	Cholesterol:	_____
<input type="checkbox"/>	Hormone Replacement:	_____
<input type="checkbox"/>	Oral Contraceptive:	_____
<input type="checkbox"/>	Other:	_____

Work Activity: Heavy Labor Lightly Labor Mostly Standing Mostly Standing Driving Active

Family History: Please 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 X = Self)

___ Alcoholism	___ Eczema	___ Miscarriage	___ Tumor(s)	___ Anemia	___ Emphysema
___ Mumps	___ Ulcer(s)	___ Cold Sores	___ Cancer	___ Epilepsy	___ Pleurisy
___ Goiter	___ Pneumonia	___ Gout	___ Polio	___ Diabetes	___ HIV / AIDS
___ Detached retina	___ Heart Disease	___ Rheumatic fever			
___ Stroke	___ Deep Vein Thrombosis	___ Other	_____		

Please check the options that apply to you.

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem only.
- 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.”
- I have no current health complaints and I am “seeking Prevention and Wellness Care” at this time.

I have read and understood all of the above questions and all of the information I have given is accurate to the best of my knowledge. Furthermore, I understand that the chiropractic spinal adjustments and care I receive in this office are not replacement for any form of diagnosis or treatment provided by other practitioners. I accept that chiropractic care is a form of wellness care to promote health and the natural healing mechanism in accordance with the scope of practice of a Doctor of Chiropractic.

Patient Signature: _____ Date: _____ Provider’s Initial _____