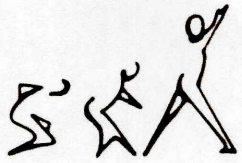
WELCOME TO



CHIROPRACTIC HEALTHCARE OF BUCKHEAD
405 PHARR ROAD NE ATLANTA, GA 3035
PHONE: (404) 231- 1872

Thank you for choosing our office! Chiropractors have become primary care doctors for millions of people around the world and we are committed to providing you and your family with the highest quality care available. Our goal is to work with you and your family to get you functioning better, healing quicker and enjoying an active, long life. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living your healthiest, happiest lifestyle.

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone #: _____ Work # _____

E-mail: _____

Date of Birth: _____ SS Number: (Last 4) _____

Referred by: _____

Occupation (Work Type): _____

Employer: _____

Marital Status: (Circle) S M D W Spouse's Name/Phone: _____

Emerg Contact: Name _____ Relationship _____

Phone: _____

OFFICE FEE SCHEDULE / FINANCIAL POLICY

Initial Visit ..... $75 - 350
Periodic Dynamic Exam ..... $75 - 300
Adjustment (spinal + joint) ..... $65 - 90
Therapies (each) including E- Stim, Traction table, Exercises ..... $25 - 30
Scraping Graston Technique $35
Cupping $35
Soft Wave Therapy (Cash, NOT covered by insurance) ..... $69 – 350

- Care Packages available

We are committed to providing you with the best quality care possible and have established financial policies to achieve that goal. You will be expected to pay for your care at the time the service is rendered, unless prior arrangements have been made. If you have health insurance that covers Chiropractic care and choose to use it, we will file the insurance claim for you. Please allow up to 24 hours to verify your benefits. In the event of a dispute, remember that your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you and you will be expected to pay your balance within 30 days. Please note that most insurance companies do not cover Critical Transition or Lifestyle care. If you have a Health Savings Account (HAS) you may request a receipt for tax purposes, indicating the total amount you have paid for Chiropractic care during the year.

Below are the categories of care we offer, categorized by frequency and patient symptomatology:

1. Crisis Care Plan: This level of care is intended for individuals experiencing significant or recurring issues such as persistent pain/ muscle aches, headaches, constipation, insomnia etc. Although pain is an unpleasant sensation, it serves as the body's way of signaling that something requires attention. Patients in need of crisis care may include those who have never received chiropractic treatment, individuals with high levels of tension and muscular imbalance, those recovering from an auto accident or other traumatic event. At this stage, our objective is to provide consistent, focused care—typically three visits per week—until the patient begins to experience a reduction in the symptoms that initially brought them in. In most cases, noticeable improvement occurs within a few weeks of treatment.

2. Critical Transition Plan: This care refers to the stage of Chiropractic treatment that bridges the gap between crisis care (focused on symptom relief and stabilization) and corrective or wellness care (focused on long-term alignment and function). During this phase, the patient has typically experienced significant improvement in pain or acute symptoms but still requires consistent care to support structural correction, muscular balance, and nervous system adaptation. The primary goal of critical transition care is to maintain the progress made during the initial phase while preventing relapse. Treatment frequency may gradually decrease as the body's biomechanics stabilize and the patient develops greater resilience and postural integrity.

3. Lifestyle Care Plan: Patients who qualify for this level of care are generally well and experience minimal symptomatology. They seek chiropractic care proactively to maintain joint mobility, support optimal neurological function, and prevent the onset of pain or dysfunction. These individuals typically integrate healthy habits such as balanced nutrition, regular exercise, and proper sleep, etc into their lifestyles. The goal of wellness care is to sustain the body's natural state of balance and function through periodic adjustments and ongoing education in spinal health and overall wellness. To maintain this, research and our experience speak to treatment frequency of once or twice a month. This approach emphasizes prevention, vitality, and long-term quality of life rather than symptom management alone.

I have read, and I understand all the information above.

Patient's Printed Name _____ **DOB** _____

Patient/Legal Guardian's Signature _____ **Date** _____ dmc

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept them for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine, thus improving nervous system functioning and overall health.

Vertebral Subluxation: A misalignment of one or more of the twenty-four vertebra in the spinal column which causes alteration of the nerve function, resulting in a lessening of the body's innate ability to express maximal health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

_____ (Initial here) I do herby authorize the Doctor of Chiropractic Healthcare of Buckhead to administer such care that is necessary for my case. This care may include consultation, examination, adjustments or any other procedure. I further understand that a fee for services rendered will be charged and that I am responsible for this fee.

_____ (Initial here) I hereby authorize Chiropractic Healthcare of Buckhead and/or any of its doctors to release my medical records when deemed necessary for further treatment, second opinions, legal issues and insurance matters.

_____ (Initial here) I authorize Chiropractic Healthcare of Buckhead and/or its doctors to bill my insurance under the condition of insurance assignment. I understand that my insurance contract is between myself and my insurance carrier. I understand that any sum of money paid under assignment by any insurance shall be credited to my account and I will be personally responsible for all the unpaid balance to the doctor.

I, (print name) _____, have read and fully understand and hereby request chiropractic care based on the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Legal Guardian's Signature **DOB** **Date** dmc

Patient's Printed Name **DOB** **Today's Date**

What activities aggravate pain? (Circle all that apply)

Bending	Concentrating	Lifting	Repetitive motions	Standing
Carrying	Coughing	Looking over shoulder	Resting	Stretching
Changing positions	Eating	Lying down	Running	Turning
Chores	Falling asleep	Pushing/ Pulling	Sitting	Twisting
Computer use	Getting up	Reaching	Squatting	Walking

What activities alleviate pain? (Circle all that apply)

Analgesic	Heat	Knees Bent	Nothing	Physical Therapy	Stretches	Support
Chiropractic	Ice	Movement	NSAIDS	Prescription meds	Siting	
Exercise	Lying down	Massage	OTC meds	Rest	Standing	

Have you previously been under Chiropractic care? _____

If yes, Office : _____ **Doctor:** _____

Do you have a preference regarding how you are adjusted? _____

_____

Is there any region of the body that you do not feel comfortable having manually adjusted or adjusted at all? _____

_____

Primary Care Physician Name: _____ **Number:** _____

Office Name: _____

Address: _____ **City:** _____ **State:** _____

Are you taking any Medications? If so please list them. _____

_____

_____

Are you taking any Supplements? If so, please list them. _____

_____

Do you have any surgically implanted metal hardware (Knees, shoulder etc) _____

Other surgeries, fractures, etc? _____

_____

Prior Car Accidents and Year? _____

_____

Have you been diagnosed with Hypertension? _____ **Diabetes?** _____ **AAA?** _____

Any other diagnosis? _____

Have you had X-ray, MRI or CT in the past 28 days? _____

dmc

Patient's Printed Name **DOB** **Today's Date**

What is the purpose of today's visit? (If you have more than one complaint, list in order of importance)

_____

_____

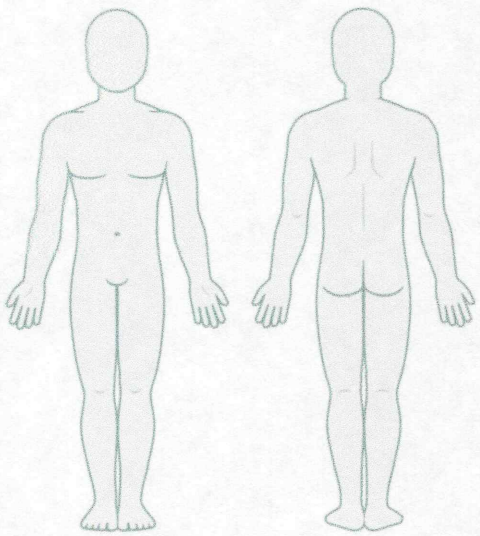
_____

Pain or problem started on: (Date)_____
Mechanism of injury (Please Check) ___ No Injury ___ Auto/ Workers comp ___ Slip, Fall, Accident
Previous Episodes of this pain? (Please check) _____ Yes _____ No
Pain Severity: (Circle) (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)
What % of the day do you feel pain? (Circle) 10 20 30 40 50 60 70 80 90 100
How long does each episode last when you are in pain?_____
Is this condition worse during certain times of day? _____ Morning? _____ Night? _____
Is this condition getting progressively worse?_____
Is this condition interfering with Work? _____ Sleep? _____ Routine? _____Other? _____
Explain how interfering:_____
Other Doctors seen for this condition?_____

Pain Site Identification

Circle or draw an X over the area of pain on the diagram.

If applicable, mark the side of the body you are feeling the pain (right or left). If you feel the pain equally on both sides, indicate this by marking both sides of the body. Please be as specific as you can with the space provided.



Quality of pain is: (Circle all that apply)

Aching	Dull	Sharp	Throbbing
Annoying	Heavy	Shock like	Tight
Burning	Intolerable	Stabbing	Tingling
Deep	Pulling	Stiffness	Radiating, if yes, where?

Frequency of pain is: (Circle all that apply)

Constant	Intermittent	Random
Frequent	On and off	Recurring

dmc

PERSONAL INJURY/ MOTOR VEHICLE ACCIDENT

Patient's Printed Name **DOB** **Today's Date**

Date of Loss/ Onset: _____ **Claim number:** _____--_____

Insurance Company: _____ Attorney:_____--_____

Describe the accident in your own words: _____=_____

_____----------_____

Year, make and model of vehicle you were in: _____

Approx. speed of your vehicle when accident occurred: _____ **Speed of other vehicle:** _____

Year, make and model of other vehicle: _____

Were you wearing a seatbelt? _____ **Did the Airbag deploy?** _____

Were you the Driver or a Passenger/ If passenger, which seat were you in? _____

Did any part of your body hit any part of the car upon impact? _____

Upon impact, which direction was your head turned? (Check) _____Forward _____Left _____Right

What was your body positioning during the collision? Leaning forward? Legs crossed? _____

_____

Did you see a flash of light upon impact? _____

Were the paramedics called/ Were you treated at the scene? _____

Did you have any major traumas? broken bones? Were you deemed unconscious? _____

_____

Were you transported to hospital by: _____Ambulance _____Drove self _____Was driven _____N/A

** Name of hospital?_____

Did you have diagnostic tests run at the hospital? Please specify. _____

Did you receive treatment at the hospital? Please specify. _____

Were you prescribed medications? Please specify. _____

Following the accident: (Circle all that apply)

Experienced pain	Irritability	Excessive fatigue	Excessive diarrhea	Vaginal bleeding	Trouble breathing
Experienced shock	Anxiety/ Depression	Night sweats	Blood in stool	Menstrual pain	Lumps in neck/ armpit/groin
Sleep disturbances	Bruises	Stomach pain	Black stools	Morning stiffness	Coughing up blood
Concentration issues	Fever	Weight loss/ gain	Blood in urine	Chest pain/ tightness	Other:
Headaches	Swollen Ankles	Excessive constipation	Painful urination	Muscle Tenderness	

Have you sought out treatment from any other healthcare providers following your accident? _____

If yes, Office: _____ **Doctor:** _____

What treatment are you receiving there? (Injections, exercises, etc.) _____

Any other home remedies or treatments: _____Ice/ Heat ____NSAIDs ____Stretching ____Bed rest _____Hot tub _____Inversion/ Traction

Was this a work related incident? _____

Describe your time lost and limitations from work and recreational activities: (Indicate number of days, weeks, etc.) _____

Neck Disability Index (Vernon – Minor)

This questionnaire helps your doctor understand how neck pain affects your everyday activities. Check **ONE** box in each section. If more than one statement applies, choose the one that best describes your situation.

SECTION 1 — PAIN INTENSITY

[ ] I have no pain at the moment.

[ ] The pain is very mild at the moment.

[ ] The pain is moderate at the moment.

[ ] The pain is fairly severe at the moment.

[ ] The pain is very severe at the moment.

[ ] The pain is the worst imaginable at the moment.

SECTION 2 — PERSONAL CARE (Washing, Dressing, etc.)

[ ] I can look after myself normally without causing extra pain.

[ ] I can look after myself normally, but it causes extra pain.

[ ] It is painful to look after myself, and I am slow and careful.

[ ] I need some help, but I manage most of my personal care.

[ ] I need help every day with most aspects of self-care.

[ ] I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3 — LIFTING

[ ] I can lift heavy weights without extra pain.

[ ] I can lift heavy weights, but it causes extra pain.

[ ] Pain prevents me from lifting heavy weights off the floor, but I can manage them if conveniently positioned (e.g., on a table).

[ ] Pain prevents me from lifting heavy weights, but I can manage light to medium weights if conveniently positioned.

[ ] I can lift very light weights.

[ ] I cannot lift or carry anything at all.

SECTION 4 — READING

[ ] I can read as much as I want with no neck pain.

[ ] I can read as much as I want with slight neck pain.

[ ] I can read as much as I want with moderate neck pain.

[ ] I cannot read as much as I want because of moderate neck pain.

[ ] I can hardly read at all because of severe neck pain.

[ ] I cannot read at all.

SECTION 5 — HEADACHES

[ ] I have no headaches at all.

[ ] I have slight headaches, which occur infrequently.

[ ] I have moderate headaches, which occur infrequently.

[ ] I have moderate headaches, which occur frequently.

[ ] I have severe headaches, which occur frequently.

[ ] I have headaches almost all the time.

SECTION 6 — CONCENTRATION

[ ] I can concentrate fully when I want to, with no difficulty.

[ ] I can concentrate fully when I want to, with slight difficulty.

[ ] I have some difficulty concentrating when I want to.

[ ] I have a lot of difficulty concentrating when I want to.

[ ] I have great difficulty concentrating when I want to.

[ ] I cannot concentrate at all.

SECTION 7 — WORK

[ ] I can do as much work as I want to.

[ ] I can do only my usual work, but no more.

[ ] I can do most of my usual work, but no more.

[ ] I cannot do my usual work.

[ ] I can hardly do any work at all.

[ ] I cannot do any work at all.

SECTION 8 — DRIVING

[ ] I can drive my car without any neck pain.

[ ] I can drive my car as long as I want, with slight neck pain.

[ ] I can drive my car as long as I want, with moderate neck pain.

[ ] I cannot drive as long as I want because of moderate neck pain.

[ ] I can hardly drive at all because of severe neck pain.

[ ] I cannot drive my car at all.

SECTION 9 — SLEEPING

[ ] I have no trouble sleeping.

[ ] My sleep is slightly disturbed (less than 1 hour without sleep).

[ ] My sleep is mildly disturbed (1–2 hours without sleep).

[ ] My sleep is moderately disturbed (2–3 hours without sleep).

[ ] My sleep is greatly disturbed (3–5 hours without sleep).

[ ] My sleep is completely disturbed (5–7 hours without sleep).

SECTION 10 — RECREATION

[ ] I can do all my recreational activities without any neck pain.

[ ] I can do all my recreational activities, but I have some neck pain.

[ ] I can do most, but not all, of my usual recreational activities because of neck pain.

[ ] I can do only a few of my usual recreational activities because of neck pain.

[ ] I can hardly do any recreational activities because of neck pain.

[ ] I cannot do any recreational activities at all.

Pain Severity Scale: Circle the number that best describes your pain.

No Pain	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

PATIENT NAME: _____ **Date of Birth:** _____

Low Back Pain and Disability Questionnaire (Revised Oswestry)

This questionnaire helps your doctor understand how back pain affects your everyday activities. Please answer every section and check **ONE** box in each section. If more than one statement applies, choose the one that best describes your situation.

SECTION 1 — PAIN INTENSITY

[ ] The pain comes and goes and is very mild.

[ ] The pain is mild and does not vary much.

[ ] The pain comes and goes and is moderate.

[ ] The pain is moderate and does not vary much.

[ ] The pain comes and goes and is severe.

[ ] The pain is severe and does not vary much.

SECTION 2 — PERSONAL CARE

[ ] I do not have to change my way of washing or dressing to avoid pain.

[ ] I do not normally change how I wash or dress, even though it causes some pain.

[ ] Washing and dressing increase the pain, but I manage without changing how I do them.

[ ] Washing and dressing increase the pain, and I need to change how I do them.

[ ] Because of pain, I need help with washing and dressing.

[ ] Because of pain, I am unable to wash and dress without help.

SECTION 3 — LIFTING

[ ] I can lift heavy weights without extra pain.

[ ] I can lift heavy weights, but it causes extra pain.

[ ] Pain prevents me from lifting heavy weights off the floor.

[ ] Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).

[ ] Pain prevents me from lifting heavy weights, but I can manage light to medium weights if conveniently positioned.

[ ] I can lift only very light weights at most.

SECTION 4 — WALKING

[ ] I have no pain when walking.

[ ] I have some pain when walking, but it does not increase with distance.

[ ] I cannot walk more than 1 km without increasing pain.

[ ] I cannot walk more than ½ km without increasing pain.

[ ] I cannot walk more than ¼ km without increasing pain.

[ ] I cannot walk at all without increasing pain.

SECTION 5 — SITTING

[ ] I can sit in any chair as long as I like.

[ ] I can sit only in my favorite chair as long as I like.

[ ] Pain prevents me from sitting for more than one hour.

[ ] Pain prevents me from sitting for more than ½ hour.

[ ] Pain prevents me from sitting for more than 10 minutes.

[ ] I avoid sitting because it increases pain straight away.

SECTION 6 — STANDING

[ ] I can stand as long as I want without pain.

[ ] I have some pain on standing, but it does not increase with time.

[ ] I cannot stand for longer than one hour without increasing pain.

[ ] I cannot stand for longer than ½ hour without increasing pain.

[ ] I cannot stand for longer than 10 minutes without increasing pain.

[ ] I avoid standing because it increases pain straight away.

SECTION 7 — SLEEPING

[ ] I get no pain in bed.

[ ] I get pain in bed, but it does not prevent me from sleeping well.

[ ] Because of pain, my normal night's sleep is reduced by less than ¼.

[ ] Because of pain, my normal night's sleep is reduced by less than ½.

[ ] Because of pain, my normal night's sleep is reduced by less than ¾.

[ ] Pain prevents me from sleeping at all.

SECTION 8 — SOCIAL LIFE

[ ] My social life is normal and gives me no pain.

[ ] My social life is normal but increases my pain.

[ ] Pain has little effect on my social life apart from limiting energetic activities (e.g., dancing).

[ ] Pain restricts my social life, and I do not go out very often.

[ ] Pain restricts my social life to my home.

[ ] I have hardly any social life because of the pain.

SECTION 9 — TRAVELLING

[ ] I get no pain whilst travelling.

[ ] I get some pain whilst travelling, but none of my usual forms of travel make it worse.

[ ] I get extra pain whilst travelling, but it does not compel me to seek alternative forms of travel.

[ ] I get extra pain whilst travelling, which compels me to seek alternative forms of travel.

[ ] Pain restricts all forms of travel.

[ ] Pain prevents all forms of travel except that done lying down.

SECTION 10 — CHANGE IN DEGREE OF PAIN

[ ] My pain is rapidly getting better.

[ ] My pain fluctuates, but overall is definitely getting better.

[ ] My pain seems to be getting better, but improvement is slow at present.

[ ] My pain is neither getting better nor worse.

[ ] My pain is gradually worsening.

[ ] My pain is rapidly worsening.

Pain Severity Scale: Circle the number that best describes your pain.

No Pain	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

PATIENT NAME: _____ **Date of Birth:** _____