1630 BUFORD HWY NE, STE 6, BUFORD, GA, 30518 | 770-945-0561

#___________

PRENATAL EVALUATION PAPERWORK

HELLO AND WELCOME!

Who may we thank for referring you / how did you hear about us? ______________________

Have you received chiropractic care in the past? ▢ No ▢ Yes (from whom?)_______________

Please fill out the following information completely and to the best of your ability.
Remember to initial the bottom of each page.

PERSONAL INFORMATION

Name: ________________________________ Date of Birth: ___________ Age:______

Preferred Name:________________________ Gender: ▢Male ▢ Female

Email: _________________________________ Marital Status: ▢S ▢ M ▢ D ▢ W

Street Address: __________________________ City/State/Zip:______________________

Cell Phone: _____________________________ Home Phone: ______________________

Occupation/Employer: _____________________ Work Phone: ______________________

Emergency Contact: ______________________ Relationship to You: _________________

Cell Phone:_____________________________ Hobbies: ___________________________

Name(s) & Age(s) of Siblings: ____

PERSONAL HEALTH BACKGROUND

Height: ___ft ___in Weight: ___lbs

What is your typical daily work activity?

▢ Sitting ▢ Standing ▢ Working at a Computer

▢ Manual Labor ▢ Light Lifting ▢ Heavy Lifting

▢ Driving ▢ Other: ______________________

Indicate if you have experienced the following:

▢N/A ▢ Been unconscious due to an illness or injury

▢ Serious illnesses, operation, or health emergency

▢ Motor vehicle accident ▢ Fractured a bone

Explain : ________________________________

Doctor/Midwife/Doula: _________________ Current Trimester/Week: ____ Due Date: _________

Do you have any genetic disorders or disabilities? ▢ No ▢ Yes: ___________________________

History of surgery? ▢ No ▢ Yes: ____

SOCIAL HISTORY INFORMATION

Do you smoke?	▢ Never	▢ In the Past	▢ Occasionally	▢ Daily
Are you exposed to secondhand smoke?	▢ Never	▢ In the Past	▢ Occasionally	▢ Daily
Do you drink alcohol?	▢ Never	▢ In the Past	▢ ___drinks /week	▢ Daily
Do you use recreational drugs?	▢ Never	▢ In the Past	▢ Occasionally	▢ Daily
How often do you exercise?	▢ Never	▢ In the Past	▢ Occasionally	▢ Daily

_______ INITIALS

NAME: ____ DATE: __________________

PRESENT ILLNESS

WHAT IS THE **MAIN** SYMPTOM/PAIN/REASON YOU ARE SEEKING CHIROPRACTIC CARE?

PRIMARY PROBLEM/CONCERN: ____

Rate your **CURRENT** pain/discomfort:___ /10 **WHEN** did the problem begin? _____________
Did anything specific start or worsen this issue?
▢ No ▢ Yes If yes, explain:____
Does the problem **RADIATE/TRAVEL/SPREAD**? ▢ No ▢ Yes Where?__________________
HOW OFTEN do you experience the problem?
☐ Constant ☐ Frequent ☐ Occasional ☐ Rare ☐ Daily ☐ Weekly ☐ Monthly ☐ AM / PM
WHEN is the problem at its worst? ▢ Morning ▢ Mid-day ▢ Evening ▢ Other ____________
What **RELIEVES** the problem? ____
What makes the problem **WORSE**? ____

Are there any **SECONDARY** health concerns you would like to address?

OTHER PROBLEM/CONCERN: ____

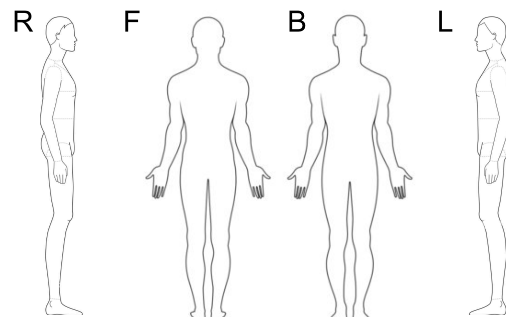
Rate your **CURRENT** pain/discomfort: ___/10 **WHEN** did the problem begin? _____________
Did you do something/did something happen that caused/aggravated the problem?
▢ No ▢ Yes If yes, explain:____
Does the problem **RADIATE** outward? ▢ No ▢ Yes If yes, where? _____________________
HOW OFTEN do you experience the problem?
▢ always ▢ often ▢ occasionally ▢ rarely ▢ monthly ▢ weekly ▢ daily (▢ AM / ▢ PM)
WHEN is the problem at its worst? ▢ Morning ▢ Mid-day ▢ Evening ▢ Other ____________
What **RELIEVES** the problem? ____
What makes the problem **WORSE**? ____

PERSONAL INFORMATION

Have you experienced this (or a similar problem) before? ▢ Yes ▢ No
What treatment did you seek? ▢ N/A _____________ How were your results? ▢ Good ▢ Poor
Help us identify past conditions or procedures that could be related to your main issue:
☐ N/A ☐ Surgeries ☐ Old injuries ☐ Childhood illness Explain: ________________
Medications or supplements you are currently taking:_________________________________

____
Have you *experienced or been diagnosed* with any of the following?
▢ N/A ▢ Pain that wakes you up at night ▢ night sweats ▢ stroke ▢ heart attack ▢ diabetes
Explain:____

Directions: On the diagrams to the RIGHT,
CIRCLE the area(s) that to your pain/symptom(s):
How would you describe the problem(s)?
☐ Aching ☐ Tight/Stiff ☐ Sharp/Stabbing
☐ Burning ☐ Numbness ☐ Tingling
☐ Radiating ☐ Deep/Dull ☐ Throbbing
▢ Other: ________________________________



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ACTIVITIES OF DAILY LIVING					
	CAN COMPLETE	CAN COMPLETE	CAN COMPLETE	**CANNOT** COMPLETE due to pain	N/A
	Without Pain or difficulty	***WITH MINIMAL*** Pain or difficulty	***WITH SEVERE*** Pain or difficulty		
Exercise	▢	▢	▢	▢	▢
Bathe/Shower	▢	▢	▢	▢	▢
Shaving	▢	▢	▢	▢	▢
Climbing Stairs	▢	▢	▢	▢	▢
Getting Dressed	▢	▢	▢	▢	▢
Household Chores	▢	▢	▢	▢	▢
Daily Physical Activity	▢	▢	▢	▢	▢
Standing	▢	▢	▢	▢	▢
Walking	▢	▢	▢	▢	▢
Sitting	▢	▢	▢	▢	▢
Yard Work	▢	▢	▢	▢	▢
Lifting	▢	▢	▢	▢	▢
Reach Overhead	▢	▢	▢	▢	▢
Bend Forward	▢	▢	▢	▢	▢
Turn Left	▢	▢	▢	▢	▢
Turn Right	▢	▢	▢	▢	▢
Seated to Standing	▢	▢	▢	▢	▢
Sleep	▢	▢	▢	▢	▢
Carry bag/Purse	▢	▢	▢	▢	▢
Run/Hike	▢	▢	▢	▢	▢
Get In/Out of Car	▢	▢	▢	▢	▢
Drive	▢	▢	▢	▢	▢
Use Computer	▢	▢	▢	▢	▢
Focus/Concentrate	▢	▢	▢	▢	▢
Other: ____________	▢	▢	▢	▢	▢

_______ INITIALS

CURRENT OR PAST HISTORY				
CONDITION	**CURRENT**	**PAST**	**NEVER**	
Acid Reflux / Heartburn / GERD	▢	▢	▢	
ADHD/ADD	▢	▢	▢	
Allergies	▢	▢	▢	
Anxiety	▢	▢	▢	
Arthritis / Joint Pain	▢	▢	▢	
Asthma / Breathing Difficulties	▢	▢	▢	
Cancer	▢	▢	▢	
Carpal Tunnel Syndrome	▢	▢	▢	
Chest Pain	▢	▢	▢	
Concussion	▢	▢	▢	
Depression	▢	▢	▢	
Diabetes	▢	▢	▢	Type I / Type II / Gestational
Disc Problems	▢	▢	▢	Where?
Ear Problems	▢	▢	▢	
Ehlers Danlos	▢	▢	▢	
Fibromyalgia	▢	▢	▢	
Headaches / Migraines	▢	▢	▢	
High / Low Blood Pressure	▢	▢	▢	
Infertility	▢	▢	▢	
Irritable Bowel Syndrome	▢	▢	▢	
Menstrual Dysfunction	▢	▢	▢	
Numbness/Tingling	▢	▢	▢	
Scoliosis	▢	▢	▢	
Sinus Problems	▢	▢	▢	
Swelling of Legs/Feet	▢	▢	▢	
Thyroid Dysfunction	▢	▢	▢	
TMJ/Jaw Pain	▢	▢	▢	
Tremors	▢	▢	▢	
*Organic/System Problems	▢	▢	▢	

***Select all that apply:** ▢ Digestive ▢ Gallbladder ▢ Cardiac ▢ Liver ▢ Stomach ▢ Pancreas ▢ Reproductive ▢ Lung/Respiratory ▢ Urinary ▢ Kidney ▢ Prostate ▢ Vision ▢ Thyroid ▢ Skin▢ Sexual ▢ Other(s) ______________________________

_______ INITIALS

NOTICE OF PRIVACY PRACTICES

This office is required by law to maintain the privacy and confidentiality of your **Personal Health Information (PHI)**.

We must also provide you with written notice regarding your rights to access your health information, as well as the circumstances under which we are permitted—by law or by office policy—to disclose information about you to a third party without your authorization.

Below is a brief summary of these permitted disclosures and your rights. A more detailed explanation is available upon request.

Please review this notice carefully, then sign and return it with your paperwork. If you would like to keep a copy for your records, please ask our front desk receptionist.

Permitted Disclosures

1. **Treatment Purposes** – Discussion with other health care providers involved in your care.
2. **Inadvertent Disclosures** – Our open treatment area allows for open discussion. If you prefer private communication, please let our staff know so we can accommodate you in a private consultation room.
3. **Payment Purposes** – To obtain payment from your insurance company or other payment sources.
4. **Emergencies** – To notify a family member in the event of a medical emergency.
5. **Public Health and Safety** – To prevent or lessen a serious or imminent threat to the health or safety of an individual or the public.
6. **Government or Law Enforcement** – To identify or locate a suspect, fugitive, material witness, or missing person.
7. **Military, National Security, or Government Benefits** – When required by law.
8. **Deceased Persons** – To assist coroners or medical examiners in the event of a patient's death.
9. **Telephone Calls, Emails, and Appointment Reminders** – We may contact you regarding missed appointments, office hour changes, or upcoming events.
10. **Change of Ownership** – In the event this practice is sold, the new owner(s) may have access to your PHI as part of the practice records.

Your Rights:

1. To receive an **accounting of disclosures**.
2. To receive a **paper copy** of the detailed Privacy Notice.
3. To request **mail delivery** to an alternate address.
4. To request **restrictions** on certain uses or disclosures of your PHI and to specify individuals with whom information may or may not be shared. While we are not required to agree, any approved restriction will remain in effect until you provide written notice to remove it.
5. To **inspect and obtain one copy** of your records at no charge, with at least 72 hours' notice.
6. To request **amendments** to your records. We are not required to agree to requested changes.
7. To obtain **one copy of your records at no charge** with timely notice (72 hours). Please note that X-rays are original medical records and cannot be released. If you wish to have copies made through an imaging center, we will assist you, but you will be responsible for the associated costs.

Complaints

If you wish to file a complaint regarding how this office handles your health information, please contact Kelly Stone, 770-945-0561. If unavailable, you may schedule an appointment with our receptionist to meet with within 72 hours (3 business days). If you are not satisfied with how your complaint is handled, you may submit a formal complaint to: U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Ave SW, Room 509F, HHH Building, Washington, DC 20201

Acknowledgment of Receipt

I acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices for this office and understand my rights and the permitted disclosures of my health information.

Patient Name: ____
Signature: ____
Date: _____________________

_______ INITIALS

CHIROPRACTIC CARE INFORMED CONSENT

I understand that chiropractic care, like all health care, carries some risk. Though rare, complications such as sprain/strain, disc irritation, minor fracture, or stroke (about 1 per 1–2 million adjustments) may occur.
My treatment goals and potential risks have been explained to me, and I consent to treatment by any method or technique the doctor deems necessary throughout my care.

Signature: ________________________________ **Date:** ___________

INFORMATION RELEASE AUTHORIZATION

I authorize Eden Chiropractic to release necessary information regarding my health condition to my insurance company, billing company, attorney, adjuster, or other healthcare providers involved in my care, as needed to process claims or coordinate treatment.
This authorization remains in effect until revoked by me in writing. A photocopy of this form is as valid as the original.
I confirm all information provided is true and accurate, and I authorize Eden Chiropractic to proceed with necessary chiropractic testing, diagnosis, analysis, and adjustments.

Signature: ________________________________ **Date:** ___________

_______ INITIALS