Brown Chiropractic
Savannah Chiropractic PC
Dr. Kevin & Dr. Gina Brown
***Historic Downtown**: 513 E. Oglethorpe Ave, Ste. O, Savannah GA 31401*
Telephone (912)447-1885 www.savannahchiropractic.com

Welcome to Brown Chiropractic,

Thank you for choosing our office. Whether you have been using chiropractic for years or are new to chiropractic, we are glad you are here! Chiropractic has proven to be a safe, effective and natural way to get healthier and to feel better without drugs or surgery. We will be working together to help you and your family reach your health and lifestyle goals. If you ever have any questions about your chiropractic care, please don't hesitate to ask, we are here to help!

Dr. Kevin & Dr. Gina

Personal and Family Health History

Name_____	Last 4 Social Security # _xxx-xx-_____
Date _____	Occupation _____
Address_____	Employer_____
City _____ State ____ Zip _____	Marital Status S M D W
Phone: (H) _____ (C) _____	Spouse's Name _____
Email_____	Spouse's Occupation _____
Date of Birth _____ (Age _____)	Who referred you to our office? _____

Circle all that Apply			**Chiropractor's notes**
1. Growth and Development			
Did you ever…....			
Have a major illness sickness?	Yes	No	
Have any Accidents?	Yes	No	
Have Surgery?	Yes	No	
Experience other traumas?	Yes	No	
2. Current Health Habits			
Did/do you...			
Smoke?	Yes	No	
Drink?	Yes	No	
Diet (do you eat healthy foods?)	Yes	No	
Drugs? (Prescriptive or Non-Prescriptive)	Yes	No	
Exercise regularly?	Yes	No	
Have sleeping problems?	Yes	No	
Have occupational stress?	Yes	No	
Have physical stress?	Yes	No	
Have mental stress?	Yes	No	

Current Health Conditions and Concerns *(list each concern separately)*

Complaint or concern #1

(What is the reason for your visit today?) _____

Pain or Problem started on_____

Cause (if known) of current condition _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

What have you done at home to help? (ice, heat medication?) _____

Is condition worse during certain times of the day?_____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting better, worse or staying the same? _____

Type of pain/discomfort: ___Sharp ____Shooting ___Dull ___Tight ___Aching ___Throbbing
other:_____

Frequency of pain is ___Constant ___Frequent ___Intermittent ___Occasional

Please indicate intensity of pain **less severe 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10 most severe**

Does the pain radiate down the legs, arms or other places? _____

What other Doctors have you seen for this condition? __ _____

What treatments have been prescribed? _____

Doctor's notes: _____

_____

_____

_____

_____

Complaint or concern #2 _____

Pain or Problem started on_____

Cause (if known) of current condition _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

What have you done at home to help? (ice, heat medication?) _____

Is condition worse during certain times of the day?_____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting better, worse or staying the same? _____

Type of pain/discomfort: ___Sharp ____Shooting ___Dull ___Tight ___Aching ___Throbbing
other:_____

Frequency of pain is ___Constant ___Frequent ___Intermittent ___Occasional

Please indicate intensity of pain **less severe 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10 most severe**

Does the pain radiate down the legs, arms or other places? _____

What other Doctors have you seen for this condition? __ _____

What treatments have been prescribed? _____

Doctor's notes: _____

_____

_____

_____

Complaint or concern #3 _____

Pain or Problem started on_____

Cause (if known) of current condition _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

What have you done at home to help? (ice, heat medication?) _____

Is condition worse during certain times of the day?_____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting better, worse or staying the same? _____

Type of pain/discomfort: ___Sharp ____Shooting ___Dull ___Tight ___Aching ___Throbbing other:_____

Frequency of pain is ___Constant ___Frequent ___Intermittent ___Occasional

Please indicate intensity of pain **less severe 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10 most severe**

Does the pain radiate down the legs, arms or other places? _____

What other Doctors have you seen for this condition? __ _____

What treatments have been prescribed? _____

Doctor's notes: _____

_____

_____

_____

Other symptoms: (please check any that you have had or are currently experiencing)

☐Headaches	☐Face Flushed	☐Light Bothers Eyes	☐Feet Cold
☐Neck Pain	☐Neck Stiff	☐Loss of Memory	☐Hands Cold
☐Sleeping Problems	☐Pins & Needles in Legs	☐Ears Ring	☐Stomach Upset
☐Back Pain	☐Pins & Needles in Arms	☐Fever	☐Constipation
☐Nervousness	☐Numbness in Fingers	☐Fainting	☐Loss of Balance
☐Tension	☐Numbness in Toes	☐Cold Sweats	☐Buzzing in Ear
☐Irritability	☐Shortness of Breath	☐Loss of Smell	
☐Chest Pains	☐Fatigue	☐Loss of Taste	
☐Dizziness	☐Depression	☐Diarrhea	

Surgery History

Surgery 1: *Reason for surgery* _____

Type of surgery _____ surgery date _____

Outcome/results _____

Doctor's notes: _____

_____

Surgery 2: *Reason for surgery* _____

Type of surgery _____ surgery date _____

Outcome/results _____

Doctor's notes: _____

_____

Surgery 3: *Reason for surgery* _____

Type of surgery _____ surgery date _____

Outcome/results _____

Doctor's notes: _____

_____

_____

Trauma History (please list any accidents, injuries or falls)

Trauma 1: Type of injury: _____ injury date: _____
How did the injury occur? _____
Treatment/outcome: _____
Doctor's notes: _____
_____
_____

Trauma 2: Type of injury: _____ injury date: _____
How did the injury occur? _____
Treatment/outcome: _____
Doctor's notes: _____
_____
_____

Trauma 3: Type of injury: _____ injury date: _____
How did the injury occur? _____
Treatment/outcome: _____
Doctor's notes: _____
_____
_____

Trauma 4: Type of injury: _____ injury date: _____
How did the injury occur? _____
Treatment/outcome: _____
Doctor's notes: _____
_____
_____

Previous Chiropractic Care

Most recent Chiropractor? _____
Dates you received care? (from when to when?) _____
Doctor's notes: _____

Previous Chiropractor? _____
Dates you received care? (from when to when?) _____
Doctor's notes: _____

Family History:

	Heart Disease	Arthritis	Cancer	Back/Neck Pain	Other _____
Father's Side	❑	❑	❑	❑	❑
Mother's Side	❑	❑	❑	❑	❑

As a result of my chiropractic care, I would like to (Please check all that apply)

☐Feel better quickly
☐Prevent my condition from getting worse
☐Have a healthier spine and nervous system
☐Live a healthier lifestyle
☐Other _____

_____ _____
Signature Date

Terms of Agreement

TERMS OF ACCEPTANCE

When a person seeks chiropractic care, and when a chiropractor accepts a clientt for such care, it is essential that both are seeking and working for the same goal – To locate, analyze and correct spinal interference to the nerve system. It is important that clients understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

We do not diagnose conditions of disease other than that which relates to vertebral subluxations (spinal misalignments). However, if during the course of a chiropractic spinal exam, we encounter complaints that warrant medical attention, we will recommend that you seek the services of a provider who specializes in that area. We offer no treatment of conditions other than that which relate to vertebral subluxations. Our primary role is to identify subluxations and our primary method of correcting them is through spinal adjustments.

I understand and agree that all services rendered to me are charged directly to me and that **I am personally responsible for payment at the time of service**. It is also understood and agreed that the amount paid to the office for x-rays is for examination only and the x-ray films will remain the legal property of the office. I hereby authorize the doctor to examine and render care. By signing below I agree to all the terms outlined.

Client or Guardian's Signature X_____ Date:_____

FEMALE CLIENTS ONLY - Non-Pregnancy Verification for X-rays

Let it be known by all people by my signature that I am not pregnant. If it later becomes known that I was pregnant during this x-ray examination, I do not hold Brown Chiropractic and the doctors liable.

Client or Guardian's Signature X_____ Date:_____

CHILDREN & MINORS ONLY – Consent to Treat a Minor

I hereby authorize the doctor and whomever he may designate as assistants to examine and administer chiropractic care as deemed necessary to my child.

Client or Guardian's Signature X_____ Date:_____

HEALTH CARE AUTHORIZATION FORM

Every medical and non-medical doctor in the United States is required by law to have clients sign the following authorization form which protects the privacy of your personal health/medical records. This form is for your benefit. If you have any questions, please do not hesitate to ask the office manager.

Patient's Full Name _____
Last 4 SS# __XXX-XX_____ Date of Birth _____/_____/_____
THE PATIENT IDENTIFIED ABOVE AUTHORIZES BROWN CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS
I give permission to Brown Chiropractic 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 Brown Chiropractic contacts me by phone at home, work or on my cell phone, I give permission to the office staff to leave a phone message on my answering machine, voice mail or email.

I give Brown Chiropractic permission to treat me in an open room where other patients may also be 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 to Brown Chiropractic 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.

By signing this form, you are giving Brown Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Client or Guardian's Signature X_____ Date:_____

Office Fee Schedule and Financial Policy

We are committed to providing the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **Everyone is expected to pay for their chiropractic care at the time the service unless they arrange a Care Plan in advance**. Care plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

Fee Schedule

Pre-Consultation	Complimentary
Complete Consultation & Health History	$50
Cervical X-Ray (each)	$35
Lumbar X-Ray (each)	$45
Spinal Adjustments	$45
Senior (Medicare) Adjustment	$38
Intersegmental Traction	$15/10 minutes
Hydromassage	$20/10 minutes

The first visit will include some or all of the following; Complete Consultation, Health History & Exam, Cervical X-Rays and Lumbar X-Rays.
***Adjustment plans provide significant discounts on x-rays, adjustments and re-exams for those who commit to recommended care plans. These plans are based on individual or family needs.**

Health Insurance

Since every plan and policy is different, we will check your chiropractic coverage and benefits after your first visit. If you have insurance that covers chiropractic, but is not with a company or plan that we directly participate with, we will give you the information you need to get reimbursed. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement.

Medicare

The amount of care Medicare allows may be limited, but they will pay for visits related to an accident, injury or exacerbation (an old problem that has recently worsened). You will need to **pay for your visits at the time of service** unless other arrangements are made. We will in turn file your Medicare and supplemental insurance claims and the checks will be sent directly to you from Medicare and your insurance company.

I have read, understand and agree to the above policies.

_____

Signature Date