empowered**BEST**
Dr. Kathryn Lawson

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Wholistic Chiropractor

1431C McClendon Drive
Decatur, GA 30033

Phone: 770-939-1177 | Fax: 770-939-0096

Patient Information

Today's Date _____ Is Visit Accident Related? (If YES, please inform receptionist) ☐ Yes ☐ No

Name _____ Social Security Number _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ May we add you to our e-mail list? ☐ Yes ☐ No

Age ____ Birth Date _____ Sex ____ Marital Status _____ # of Children _____

Occupation _____ Employer _____

Name of Spouse _____ Spouse's Phone Number _____

Spouse's Occupation _____ Spouse's Employer _____

Emergency Contact Name _____ Phone Number _____

Whom may we thank for referring you to us? _____

Purpose of this appointment

Briefly describe symptoms

How has this affected your daily activities? _____

Date symptoms appeared or accident happened _____

Have you ever had a similar condition? ☐ Yes ☐ No

If Yes, when and describe

List any operations you have had and dates

Have you ever seen a chiropractor? ☐ Yes ☐ No

Date of last physical examination _____ Doctor's Name _____

Are you allergic to any medication? ☐ Yes ☐ No If yes, list _____

Are you taking any medication? ☐ Yes ☐ No If yes, list _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare, operations, and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that I will be financially responsible for all collection/legal fees incurred for the collection of any unpaid balance. **I understand that the office requires 24 hour notice of cancellation of my appointment.**

Patient Signature _____ Date _____

Medical / Family History

Please indicate which conditions have been experienced by marking the appropriate boxes.

AIDS	☐ Self	☐ Mother	☐ Father	**anemia**	☐ Self	☐ Mother	☐ Father
anemia	☐ Self	☐ Mother	☐ Father	**HIV/ ARC**	☐ Self	☐ Mother	☐ Father
arthritis	☐ Self	☐ Mother	☐ Father	**kidney disorder**	☐ Self	☐ Mother	☐ Father
asthma	☐ Self	☐ Mother	☐ Father	**bowel control loss**	☐ Self	☐ Mother	☐ Father
back pain	☐ Self	☐ Mother	☐ Father	**menstrual cramps**	☐ Self	☐ Mother	☐ Father
bladder trouble	☐ Self	☐ Mother	☐ Father	**multiple sclerosis**	☐ Self	☐ Mother	☐ Father
bone fracture	☐ Self	☐ Mother	☐ Father	**muscular dystrophy**	☐ Self	☐ Mother	☐ Father
cancer	☐ Self	☐ Mother	☐ Father	**neck pain**	☐ Self	☐ Mother	☐ Father
chest pain	☐ Self	☐ Mother	☐ Father	**nervousness**	☐ Self	☐ Mother	☐ Father
concussion	☐ Self	☐ Mother	☐ Father	**numbness**	☐ Self	☐ Mother	☐ Father
convulsions	☐ Self	☐ Mother	☐ Father	**polio**	☐ Self	☐ Mother	☐ Father
diabetes	☐ Self	☐ Mother	☐ Father	**poor circulation**	☐ Self	☐ Mother	☐ Father
indigestion	☐ Self	☐ Mother	☐ Father	**hepatitis**	☐ Self	☐ Mother	☐ Father
dislocated joints	☐ Self	☐ Mother	☐ Father	**rheumatic fever**	☐ Self	☐ Mother	☐ Father
epilepsy	☐ Self	☐ Mother	☐ Father	**rheumatism**	☐ Self	☐ Mother	☐ Father
German Measles	☐ Self	☐ Mother	☐ Father	**scarlet fever**	☐ Self	☐ Mother	☐ Father
headaches	☐ Self	☐ Mother	☐ Father	**serious injury**	☐ Self	☐ Mother	☐ Father
heart trouble	☐ Self	☐ Mother	☐ Father	**sinus trouble**	☐ Self	☐ Mother	☐ Father
reproductive disorders	☐ Self	☐ Mother	☐ Father	**tuberculosis**	☐ Self	☐ Mother	☐ Father
high blood pressure	☐ Self	☐ Mother	☐ Father	**venereal disease**	☐ Self	☐ Mother	☐ Father

Medical Conditions

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition

Date of last physical exam _____

Have you ever had a metal implant? ☐ Yes ☐ No

Accident History

Surgical History

Current Conditions

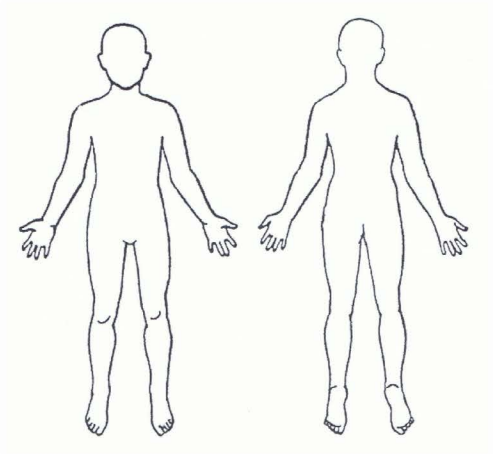
Please Describe Present Major Complaints

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

Rate your pain today
(no pain) (unbearable pain)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Mark an X on the picture where you have pain or other symptoms



When and how did it occur?

Symptoms are worse in

- ☐ Morning
- ☐ Afternoon
- ☐ Night

Symptoms developed from

- ☐ Job Related Injury
- ☐ Auto Accident
- ☐ Illness
- ☐ Unknown Cause
- ☐ Gradual Onset

Symptoms/ Complaints

- ☐ Come and Go
- ☐ Are Constant

Current Condition Continued

Symptoms have persisted for #

Hours _____ Days _____ Weeks _____ Months _____ Years _____

Have you ever had this before? If yes, when

☐ Yes ☐ No _____

Name and location of doctors previously seen for present condition(s)

Are you allergic to any medication? ☐ Yes ☐ No What Kind? _____

Are you taking any medication? ☐ Yes ☐ No What Kind? _____

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period? _____

Please check the following activities that **aggravate** your condition:

☐ bending ☐ reaching ☐ straining at stool ☐ coughing ☐ sitting ☐ turning head
☐ lifting ☐ sneezing ☐ walking ☐ laying down ☐ standing

Please check the following activities that **relieve** your condition:

☐ bending ☐ sitting ☐ lifting ☐ standing ☐ lying down ☐ turning head ☐ reaching
☐ walking

Please check any **additional symptoms** you may be experiencing:

☐ blurred vision ☐ buzzing in ears ☐ cold feet ☐ cold hands
☐ cold sweats ☐ concentration loss/confusion ☐ constipation ☐ depression/ weeping spells
☐ diarrhea ☐ dizziness ☐ face flushed ☐ fainting
☐ fatigue ☐ fever ☐ seems to heavy ☐ headaches
☐ insomnia ☐ light bothers eyes ☐ loss of balance ☐ loss of smell
☐ loss of taste ☐ resistance to colds ☐ muscle jerking ☐ numbness in fingers
☐ numbness in toes ☐ pins and needles in arms ☐ pins and needles in legs ☐ ringing in ears
☐ shortness of breath ☐ stiff neck ☐ stomach upset

Patient Authorization

Why chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Comprehensive Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care
☐ Comprehensive Care ☐ Doctor to select type of care appropriate for my condition

I hereby authorize the Doctor to treat my condition as she deems appropriate through the use of manipulations, therapy, and such additional procedures as are considered therapeutically necessary in the course of said treatment. I hereby certify that I have read and fully understand this Authorization for chiropractic treatment. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

Patient Signature _____ Date _____

Chemical Balance Questionnaire

Speed of healing is determined by **chemical balance** in the body. Chemical balance is determined, in large, by **what you eat**. Please indicate the amounts and frequencies you partake in the following. **(BE HONEST!)**

	Per Day	Per Week
1. Coffee (caffeinated/ decaf)	cups	cups
2. Tea (herbal/ regular)	cups	cups
3. Sugar, sweets, desserts, candy	times	times
4. Salt, salty snacks, chips, etc.	servings	servings
5. Do you add salt to food at mealtime?	☐ Yes ☐ No ☐ Occasionally	
6. Red Meat (beef, pork, bacon, ham, etc.	servings	servings
7. Chicken / Fish	servings	servings
8. Milk	glasses/ times	glasses/ times
Other Dairy (cheese, ice cream, etc.)	oz	oz
9. Water	glasses	glasses
10. Fresh Fruits	servings	servings
11. Fresh Vegetables (non-canned)	servings	servings
12. Pasta, Breads (made with white flour)	servings	servings
13. Whole Grain Foods	servings	servings
14. Artificially sweetened (Splenda, Sweet-N_Low, Equal, Aspartame, etc.)	servings	servings
15. Fast Food (McDonalds, Hardees, etc.)	times	times
16. Fats (nuts, avocado, coconut, oils, etc.)	times	times
17. Processed Foods (cereals, boxed or frozen meals)	times	times
18. Alcoholic beverages	servings	servings
19. Soft Drinks (regular / caffeine-free)	oz	oz
Diet Soda	oz	oz
20. Smoking	packs	packs

Cravings (check ones that apply):

☐ salt ☐ sugar ☐ chocolate ☐ bitter ☐ carbs/ starches ☐ ice

What is a typical breakfast for you?

What is a typical lunch for you?

What is a typical evening meal for you?

List any vitamins/ herbs you are currently taking

Major life changes (divorce, losses, trauma, etc.)