



# EDEN

## CHIROPRACTIC

*rooted in health*

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

# \_\_\_\_\_

### INITIAL 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 Children: \_\_\_\_\_

#### PERSONAL HEALTH BACKGROUND

Height: \_\_\_\_ ft \_\_\_\_ in Weight: \_\_\_\_ lbs *Indicate if you have experienced the following:*  
What is your typical daily work activity? ☐ N/A ☐ Been unconscious due to an illness or injury  
☐ Sitting ☐ Standing ☐ Working at a Computer ☐ Serious illnesses, operation, or health emergency  
☐ Manual Labor ☐ Light Lifting ☐ Heavy Lifting ☐ Motor vehicle accident ☐ Fractured a bone  
☐ Driving ☐ Other: \_\_\_\_\_ Explain : \_\_\_\_\_  
Do you have any genetic disorders or disabilities? ☐ No ☐ Yes: \_\_\_\_\_  
History of surgery? ☐ No ☐ Yes: \_\_\_\_\_

#### SOCIAL HISTORY INFORMATION

|                                      |                                |                                      |                                            |                                |
|--------------------------------------|--------------------------------|--------------------------------------|--------------------------------------------|--------------------------------|
| Do you smoke?                        | <input type="checkbox"/> Never | <input type="checkbox"/> In the Past | <input type="checkbox"/> Occasionally      | <input type="checkbox"/> Daily |
| Are you exposed to secondhand smoke? | <input type="checkbox"/> Never | <input type="checkbox"/> In the Past | <input type="checkbox"/> Occasionally      | <input type="checkbox"/> Daily |
| Do you drink alcohol?                | <input type="checkbox"/> Never | <input type="checkbox"/> In the Past | <input type="checkbox"/> ____ drinks /week | <input type="checkbox"/> Daily |
| Do you use recreational drugs?       | <input type="checkbox"/> Never | <input type="checkbox"/> In the Past | <input type="checkbox"/> Occasionally      | <input type="checkbox"/> Daily |
| How often do you exercise?           | <input type="checkbox"/> Never | <input type="checkbox"/> In the Past | <input type="checkbox"/> Occasionally      | <input type="checkbox"/> Daily |

\_\_\_\_ INITIALS

## 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):

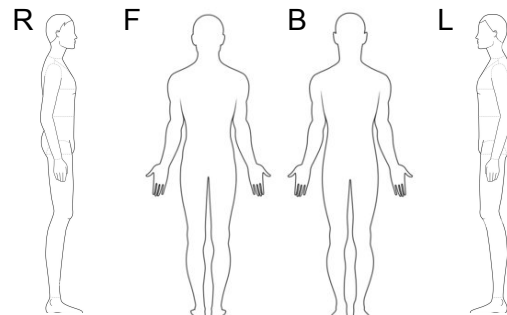
How would you describe the problem(s)?

☐ Aching ☐ Tight/Stiff ☐ Sharp/Stabbing

☐ Burning ☐ Numbness ☐ Tingling

☐ Radiating ☐ Deep/Dull ☐ Throbbing

☐ Other: \_\_\_\_\_



\_\_\_\_INITIALS

| ACTIVITIES OF DAILY LIVING |                                             |                                                  |                                                 |                                                 |                          |
|----------------------------|---------------------------------------------|--------------------------------------------------|-------------------------------------------------|-------------------------------------------------|--------------------------|
|                            | CAN<br>COMPLETE                             | CAN<br>COMPLETE                                  | CAN<br>COMPLETE                                 | <b><u>CANNOT</u></b><br>COMPLETE<br>due to pain |                          |
|                            | <b><u>Without</u></b> Pain<br>or difficulty | <b><u>WITH MINIMAL</u></b><br>Pain or difficulty | <b><u>WITH SEVERE</u></b><br>Pain or difficulty |                                                 | N/A                      |
| Exercise                   | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Bathe/Shower               | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Shaving                    | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Sexual Activity            | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Climbing Stairs            | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Getting Dressed            | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Household Chores           | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Daily Physical Activity    | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Standing                   | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Walking                    | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Sitting                    | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Yard Work                  | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Lifting                    | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Reach Overhead             | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Bend Forward               | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Turn Left                  | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Turn Right                 | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Seated to Standing         | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Sleep                      | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Carry bag/Purse            | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Run/Hike                   | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Get In/Out of Car          | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Drive                      | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Use Computer               | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Focus/Concentrate          | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |
| Other: _____               | <input type="checkbox"/>                    | <input type="checkbox"/>                         | <input type="checkbox"/>                        | <input type="checkbox"/>                        | <input type="checkbox"/> |

\_\_\_\_\_INITIALS

## CURRENT OR PAST HISTORY

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

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

\_\_\_\_\_ INITIALS

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## NOTICE OF PRIVACY PRACTICES

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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

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### CHIROPRACTIC CARE INFORMED CONSENT

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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:** \_\_\_\_\_

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### X-RAY CONSENT

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X-rays may be used to help locate and analyze spinal subluxations. The doctors at Eden Chiropractic do not diagnose or treat medical conditions, but I will be informed of any abnormal findings. I have been advised of the potential risks of ionizing radiation, including those to an unborn child, and consent to any X-rays deemed necessary.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Women Only) PLEASE CHECK APPLICABLE BOX- To the best of my knowledge:

☐ I am / may be pregnant and **DO NOT authorize** X-rays at this time.

☐ I am **NOT** pregnant at this time

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### INFORMATION RELEASE AUTHORIZATION

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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