

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

Phone # (H) _____ (W) _____ (Other) _____

Can we call you at work? Yes No

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Has it been reported? Yes No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ <input type="checkbox"/> Other _____ |

Do you exercise: Frequently Moderately Occasionally None

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

• I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

• **SIGNATURE (X)** _____ **DATE** _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

Please circle YES or NO for the following questions:

- | | | |
|--|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands? | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands? | NO | YES |
| 3. Do your hands or arms fall asleep regularly? | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms? | NO | YES |
| 5. Do you suffer from a loss of handgrip strength? | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet? | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet? | NO | YES |
| 8. Do our legs or feet fall asleep regularly? | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet? | NO | YES |
| 10. Do you suffer from cold hands or feet? | NO | YES |
| 11. Have you tried any medications such as anti-inflammatory?
If yes, what kind of medication? | NO | YES |
| <hr/> | | |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before?
If yes: When? For how long? What kind? | NO | YES |
| <hr/> | | |
| 13. Have you had an MRI?
If yes: When? Who ordered it? What was it ordered for? | NO | YES |
| <hr/> | | |
| 14. Have you used any splint or braces or other prescribed treatment by an MD?
If yes: When? What kind? Who ordered it? | NO | YES |
| <hr/> | | |
| 15. If you have tried any treatment or medications, did this make your problem better? | NO | YES |

<p>NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.</p>

Symptom Checklist

Name: _____ **Date:** _____

Please put a mark next to each symptom that you have experienced in the past 60 days:

- | | | |
|---|---|---|
| <input type="checkbox"/> Aches and pains | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Morning fatigue |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Elevated triglycerides | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Evening fatigue | <input type="checkbox"/> Oily skin |
| <input type="checkbox"/> Autoimmune illness | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Persistent Canker Sore |
| <input type="checkbox"/> Binge Eating | <input type="checkbox"/> Feeling cold all the time | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Fibrocystic breasts | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Blood sugar imbalance | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Bone loss | <input type="checkbox"/> Foggy thinking | <input type="checkbox"/> Reflux or Heartburn |
| <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Food Cravings | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Burned out feeling | <input type="checkbox"/> Frequent Sneezing | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Chest Congestion | <input type="checkbox"/> Gas | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Stomach Pains or Cramping |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Heavy menses | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hives | <input type="checkbox"/> Stuffy or Runny nose |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Susceptibility to Infections |
| <input type="checkbox"/> Cystic Ovaries | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Thinning hair |
| <input type="checkbox"/> Decreased erections | <input type="checkbox"/> Inability to lose weight | <input type="checkbox"/> Thinning skin |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Increased body/facial hair | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Decreased Mental Sharpness | <input type="checkbox"/> Increased urinary urge | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Decreased muscle mass | <input type="checkbox"/> Infertility problems | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Decreased stamina | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Water Retention |
| <input type="checkbox"/> Decreased urine flow | <input type="checkbox"/> Irritable | <input type="checkbox"/> Watery eyes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Weight gain in waist |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lack of motivation | |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Menstrual irregularities | |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Migraines | |



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Rehabilitation Center**

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DIRECTIONS

FROM HWY 75N: TAKE 285E TO 400N. TAKE EXIT 5A (DUNWOODY) GO TO FIRST INTERSECTION (PEACHTREE DUNWOODY) AND MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES. YOU WILL PASS THE NORTH SPRINGS MARTA STATION ON THE LEFT AS YOU APPROACH OUR OFFICE. 7100 PEACHTREE DUNWOODY RD IS ON THE RIGHT HAND SIDE. WE ARE LOCATED IN THE SINGLE BRICK BUILDING IN SUITE 100.

FROM COSTCO: TURN LEFT OUT OF COSTCO'S PARKING LOT ONTO PEACHTREE DUNWOODY RD. GO THROUGH 4 STOP LIGHTS. THE LAST LIGHT WILL BE THE NORTH SPRINGS MARTA STATION. GO STRAIGHT THROUGH THAT LIGHT AND OUR OFFICE WILL BE APPROXIMATELY .4 MILES ON YOUR RIGHT AT 7100 PEACHTREE DUNWOODY ROAD. WE ARE LOCATED IN THE SINGLE BRICK BUILDING IN SUITE 100.

FROM 85: TAKE 85N TO GA 400N. TAKE EXIT 5A (DUNWOODY) GO TO FIRST INTERSECTION (PEACHTREE DUNWOODY RD) AND MAKE A LEFT. CONTINUE ON PEACHTREE DUNWOODY ROAD APPROXIMATELY 1.2 MILES. YOU WILL PASS THE NORTH SPRINGS MARTA STATION ON THE LEFT AS YOU APPROACH OUR OFFICE. 7100 PEACHTREE DUNWOODY RD IS ON THE RIGHT HAND SIDE. WE ARE LOCATED IN THE SINGLE BRICK BUILDING IN SUITE 100.

FROM NORTH SPRINGS MARTA STATION: CROSS AT THE LIGHT SO THAT YOU ARE ON THE OPPOSITE SIDE OF THE STREET. TURN LEFT AND CONTINUE ON PEACHTREE DUNWOODY ROAD FOR APPROXIMATELY .4 MILES AND OUR OFFICE WILL BE ON YOUR RIGHT AT 7100 PEACHTREE DUNWOODY ROAD. WE ARE LOCATED IN THE SINGLE BRICK BUILDING IN SUITE 100.