Date: ____________________ **WELCOME TO:**

Patient Information

Name: ____
Last First MI

Address: ____
Street City State Zip

Phone # : (Mobile) ______________________ (Home) ____________________ (Work) _______________

Can we leave a voicemail or text message? □ Yes □ No

Email: ____ Date of Birth: __________________

Gender: □ Male □ Female SS# ____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Minor

Employer: ____

How did you hear about us? □ Personal Referral □ Insurance □ Social Media

What is your MAJOR COMPLAINT? ____

What caused or started your condition? ____

What aggravates condition? Sitting / Standing / Sitting to Standing / Walking / Bending / Turning head / Driving

How long have you had this condition? ____

Is this condition: Getting worse / Getting better / Not Changing. * Is condition interfering with: Daily Activity / Work / Sleep

Have you seen another healthcare professional for this condition? □ Yes □ No

What do you believe is wrong with you? ____

HAVE YOU EVER:

Had a Concussion? □ Yes □ No

Been treated for lower back pain, sciatica or disc disorder? □ Yes □ No

Been treated for Headaches or Neck Pain? □ Yes □ No

Had a fracture or broken bone? □ Yes □ No

Been treated at an emergency room or clinic for trauma? □ Yes □ No

If Yes, Please explain ____

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

Please list any medication you are currently taking.

____

____

Please list any ALLERGIES: ____

Emergency Contact: Name:________________________________ Phone: ____________________________

Patient / Parent Signature:____ Date:____________________

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

HEALTH HISTORY

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

Please check to indicate if you have experienced any of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs	☐ Depression	☐ Loss of Taste
☐ Arm/Hand Pain	☐ Fatigue	☐ Nervousness	☐ Loss of Memory
☐ Leg/Knee pain	☐ Sleeping Difficulties	☐ Tension	☐ Jaw Problems
☐ Headaches	☐ Loss of Smell	☐ Cold Sweats	☐ Constipation
☐ Dizziness	☐ Allergies	☐ Stomach Problems	☐ Shortness of Breath
☐ Asthma	☐ Blurred Vision	☐ Night Pain	☐ Bowel/Bladder
☐ Chest Pain	☐ Nausea	☐ Cold Feet	☐ Fainting

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

☐ Aids/HIV	☐ Chicken Pox	☐ Liver Disease	☐ Psychiatric Care
☐ Alcoholism	☐ Diabetes	☐ Measles	☐ Rheumatoid Arthritis
☐ Allergy Shots	☐ Emphysema	☐ Migraines	☐ Rheumatic Fever
☐ Anemia	☐ Epilepsy	☐ Miscarriage	☐ Scarlet Fever
☐ Anorexia	☐ Glaucoma	☐ Mononucleosis	☐ Stroke
☐ Appendicitis	☐ Goiter	☐ Multiple Sclerosis	☐ Thyroid Problems
☐ Arthritis	☐ Gonorrhea	☐ Mumps	☐ Tonsillitis
☐ Asthma	☐ Gout	☐ Osteoporosis	☐ Tuberculosis
☐ Bleeding Disorder	☐ Heart Disease	☐ Pacemaker	☐ Tumors/Growths
☐ Breast Lump	☐ Hepatitis	☐ Parkinson's Disease	☐ Typhoid Fever
☐ Bronchitis	☐ Hernia	☐ Pinched Nerve	☐ Ulcers
☐ Bulimia	☐ Herniated Disc	☐ Pneumonia	☐ Vaginal Infections
☐ Cancer	☐ Herpes	☐ Polio	☐ Venereal Disease
☐ Cataracts	☐ High Cholesterol	☐ Prostate Problems	☐ Whooping Cough
☐ Chemical Dependent	☐ Kidney Disease	☐ Prosthesis	Other_______________

Is there a family history of any of the following conditions? (Indicate family member)

☐ Heart Disease________________ ☐ Diabetes________________________

☐ Cancer________________________ ☐ Arthritis________________________ ☐ Other____________________________

PAST HEALTH HISTORY

Please list all surgeries you have had:

Type____ Date____________________________ Doctor__________________________

Type____ Date____________________________ Doctor__________________________

Type____ Date____________________________ Doctor__________________________

Please list any prior history of current complaints:

Date___________ Complaint ____________________Treatment ______________________________ Result________________

Date___________ Complaint ____________________Treatment ______________________________ Result________________

Date___________ Complaint ____________________Treatment ______________________________ Result________________

Patient / Parent Signature:____ Date:____________________________

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

OCCUPATIONAL INFORMATION: (Job Involves)

□ Sitting □ Standing How long _______________ □ Desk □ Counter □ Other _______________________

□ Lifting □ Heavy Labor □ Light Labor □ Bending □ Stooping □ Twisting □ Turning

How Long do you sit at a desk working at a computer or doing paper work? ________________________________

Do any of your work activities aggravate your present main complaints? Please describe:

____

HEALTH HABITS:

□ Caffeine □ Alcohol □ Tobacco □ Sugar Any Special Diet? ____

How many hours per night do you sleep? ______________ Is your sleep restful? □ Yes □ No

DISABILITY: Do you have a permanent disability rating? □ Yes □ No If yes explain

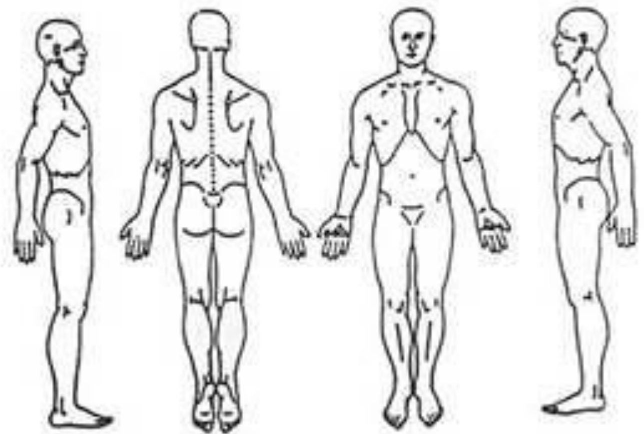
____

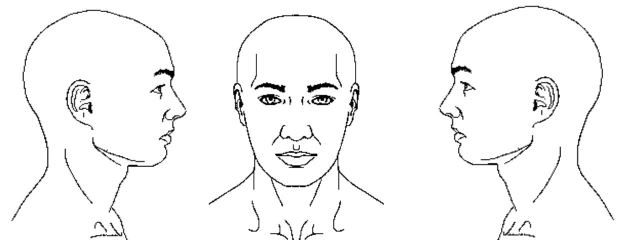
CURRENT COMPLAINTS - *INDICATE ALL OF YOUR AREAS OF PAIN!!*

Dear Patient, Thank You for your patience and for being as specific as possible when filling out these forms. Please, do your best to present your complaints in order of severity. There are more complaints sheets at front desk.

1st COMPLAINT_______________________________________

Please mark the areas of pain on the figures below





Date when symptom first appeared _________________

Type of pain:

□ Dull □ Sharp □ Aching □ Cutting □ Throbbing □ Burning

□ Numbing □ Tingling □ Cramping □ Spasm □ Stinging

□ Shooting □ Constricting

How often do you experience the symptom?

□ Constant 76-100% □ Frequent 51-75%

□ Intermittent 26-50% □ Occasional 0-25%

Pain intensity? (In relation to your activities/work/hobbies)

□ Doesn't Affect □ Somewhat Affects

□ Seriously Affects □ Prevents Activity

Does pain radiate/affect/shoot into/sting/numb into?

	Left	Right	Both
□ Head	□	□	□
□ Neck	□	□	□
□ Shoulder	□	□	□
□ Arm	□	□	□
□ Hand	□	□	□
□ Hip	□	□	□
□ Leg	□	□	□
□ Foot	□	□	□

Actions affecting this symptom?

	Brings On	Aggravates	Relieves
Bending forward	□	□	□
Bending back	□	□	□
Bending left	□	□	□
Bending right	□	□	□
Twisting left	□	□	□
Twisting right	□	□	□
Coughing	□	□	□
Sneezing	□	□	□
Lifting/Straining	□	□	□
Standing	□	□	□
Sitting	□	□	□

How bad is your pain? (indicate 0 no pain to 10 unbearable)

0--------------------------------5---------------------------------10

When is the pain at its worse?

□ Morning □ Afternoon □ Evening □ Bedtime

Patient / Parent Signature:____ Date:___________________________

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

2ND COMPLAINT_______________________________

Date when symptom first appeared ___________________

-Type of pain:

□ Dull □ Sharp □ Aching □ Cutting □ Throbbing
□ Burning □ Numbing □ Tingling □ Cramping □ Spasm
□ Stinging □ Shooting □ Constricting

-How often do you experience the symptom?

□ Constant 76-100% □ Frequent 51-75%
□ Intermittent 26-50% □ Occasional 0-25%

-Pain intensity? (In relation to your activities/work/hobbies)

□ Doesn't Affect □ Somewhat Affects
□ Seriously Affects □ Prevents Activity

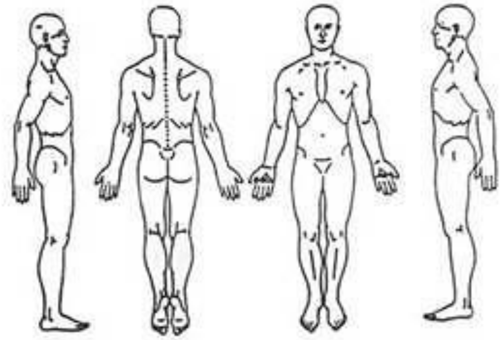
-Does pain radiate/affect/shoot into/sting/numb into?

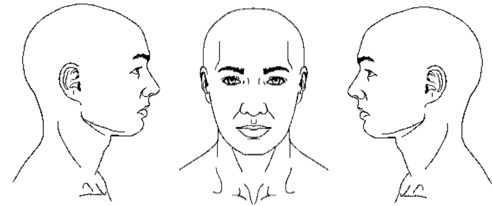
____

-Actions affecting this symptom?

	Brings On	Aggravates	Relieves
Bending forward/back	□	□	□
Bending left/right	□	□	□
Twisting left/right	□	□	□
Coughing	□	□	□
Sneezing	□	□	□
Lifting/Straining	□	□	□
Standing	□	□	□
Sitting	□	□	□

Please mark the areas of pain on the figures below





-How bad is your pain? (indicate 0 no pain to 10 unbearable)

0--------------------------------5---------------------------------10

-When is the pain at its worse?

□ Morning □ Afternoon □ Evening □ Bedtime

==

3RD COMPLAINT _______________________________

Date when symptom first appeared ____________________

-Type of pain:

□ Dull □ Sharp □ Aching □ Cutting □ Throbbing
□ Burning □ Numbing □ Tingling □ Cramping □ Spasm
□ Stinging □ Shooting □ Constricting

-How often do you experience the symptom?

□ Constant 76-100% □ Frequent 51-75%
□ Intermittent 26-50% □ Occasional 0-25%

-Pain intensity? (In relation to your activities/work/hobbies)

□ Doesn't Affect □ Somewhat Affects
□ Seriously Affects □ Prevents Activity

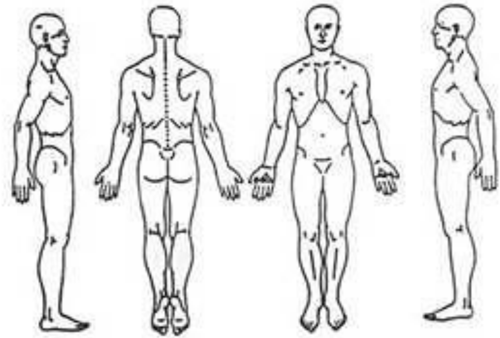
-Does pain radiate/affect/shoot into/sting/numb into?

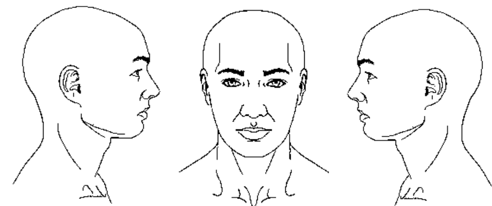
____

-Actions affecting this symptom?

	Brings On	Aggravates	Relieves
Bending forward/back	□	□	□
Bending left/right	□	□	□
Twisting left/right	□	□	□
Coughing	□	□	□
Sneezing	□	□	□
Lifting/Straining	□	□	□
Standing	□	□	□
Sitting	□	□	□

Please mark the areas of pain on the figures below





-How bad is your pain? (indicate 0 no pain to 10 unbearable)

0--------------------------------5---------------------------------10

-When is the pain at its worse?

□ Morning □ Afternoon □ Evening □ Bedtime

Patient / Parent Signature:____ Date:_________________________

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

4TH COMPLAINT ________________________________

Date when symptom first appeared _____________________

-Type of pain:

□ Dull □ Sharp □ Aching □ Cutting □ Throbbing
□ Burning □ Numbing □ Tingling □ Cramping □ Spasm
□ Stinging □ Shooting □ Constricting

-How often do you experience the symptom?

□ Constant 76-100% □ Frequent 51-75%
□ Intermittent 26-50% □ Occasional 0-25%

-Pain intensity? (In relation to your activities/work/hobbies)

□ Doesn't Affect □ Somewhat Affects
□ Seriously Affects □ Prevents Activity

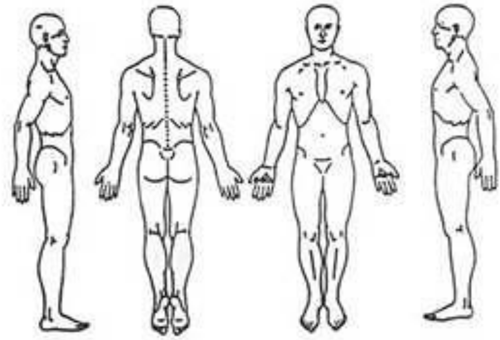
-Does pain radiate/affect/shoot into/sting/numb into?

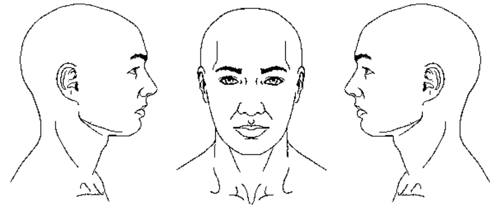
____

-Actions affecting this symptom?

	Brings On	Aggravates	Relieves
Bending forward/back	□	□	□
Bending left/right	□	□	□
Twisting left/right	□	□	□
Coughing	□	□	□
Sneezing	□	□	□
Lifting/Straining	□	□	□
Standing	□	□	□
Sitting	□	□	□

Please mark the areas of pain on the figures below





-How bad is your pain? (indicate 0 no pain to 10 unbearable)

0--------------------------------5---------------------------------10

-When is the pain at its worse?

□ Morning □ Afternoon □ Evening □ Bedtime

5TH COMPLAINT ________________________________

Date when symptom first appeared ___________________

-Type of pain:

□ Dull □ Sharp □ Aching □ Cutting □ Throbbing
□ Burning □ Numbing □ Tingling □ Cramping □ Spasm
□ Stinging □ Shooting □ Constricting

-How often do you experience the symptom?

□ Constant 76-100% □ Frequent 51-75%
□ Intermittent 26-50% □ Occasional 0-25%

-Pain intensity? (In relation to your activities/work/hobbies)

□ Doesn't Affect □ Somewhat Affects
□ Seriously Affects □ Prevents Activity

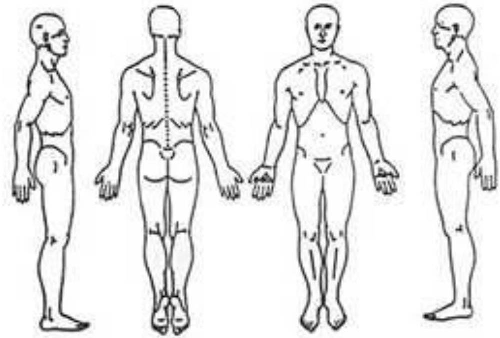
-Does pain radiate/affect/shoot into/sting/numb into?

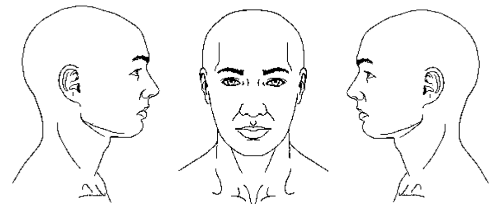
____

-Actions affecting this symptom?

	Brings On	Aggravates	Relieves
Bending forward/back	□	□	□
Bending left/right	□	□	□
Twisting left/right	□	□	□
Coughing	□	□	□
Sneezing	□	□	□
Lifting/Straining	□	□	□
Standing	□	□	□
Sitting	□	□	□

Please mark the areas of pain on the figures below





-How bad is your pain? (indicate 0 no pain to 10 unbearable)

0--------------------------------5---------------------------------10

-When is the pain at its worse?

□ Morning □ Afternoon □ Evening □ Bedtime

Patient / Parent Signature:____ Date:___________________________

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

6TH COMPLAINT ________________________________

Date when symptom first appeared ____________________

-Type of pain:
□ Dull □ Sharp □ Aching □ Cutting □ Throbbing
□ Burning □ Numbing □ Tingling □ Cramping □ Spasm
□ Stinging □ Shooting □ Constricting

-How often do you experience the symptom?
□ Constant 76-100% □ Frequent 51-75%
□ Intermittent 26-50% □ Occasional 0-25%

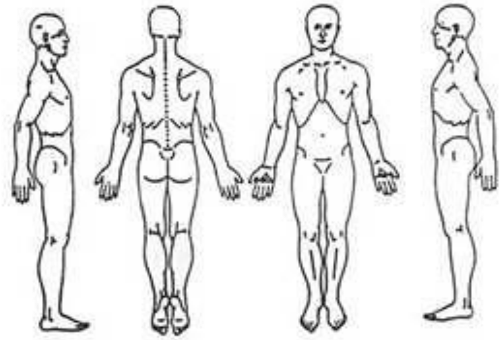
-Pain intensity? (In relation to your activities/work/hobbies)
□ Doesn't Affect □ Somewhat Affects
□ Seriously Affects □ Prevents Activity

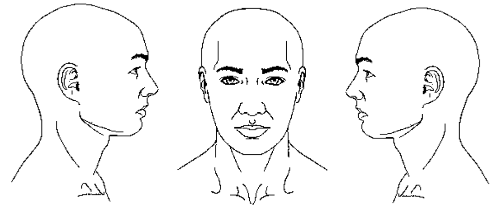
-Does pain radiate/affect/shoot into/sting/numb into?
____

-Actions affecting this symptom?

	Brings On	Aggravates	Relieves
Bending forward/back	□	□	□
Bending left/right	□	□	□
Twisting left/right	□	□	□
Coughing	□	□	□
Sneezing	□	□	□
Lifting/Straining	□	□	□
Standing	□	□	□
Sitting	□	□	□

Please mark the areas of pain on the figures below





-How bad is your pain? (indicate 0 no pain to 10 unbearable)
0--------------------------------5---------------------------------10

-When is the pain at its worse?
□ Morning □ Afternoon □ Evening □ Bedtime

7TH COMPLAINT ________________________________

Date when symptom first appeared ____________________

-Type of pain:
□ Dull □ Sharp □ Aching □ Cutting □ Throbbing
□ Burning □ Numbing □ Tingling □ Cramping □ Spasm
□ Stinging □ Shooting □ Constricting

-How often do you experience the symptom?
□ Constant 76-100% □ Frequent 51-75%
□ Intermittent 26-50% □ Occasional 0-25%

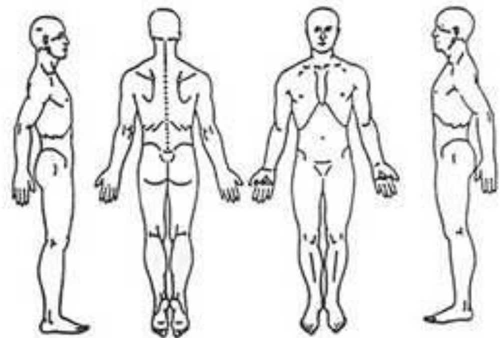
-Pain intensity? (In relation to your activities/work/hobbies)
□ Doesn't Affect □ Somewhat Affects
□ Seriously Affects □ Prevents Activity

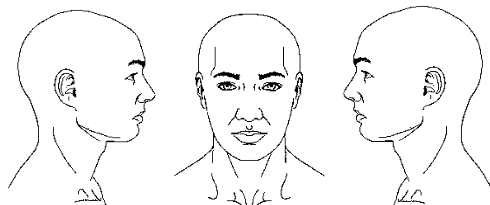
-Does pain radiate/affect/shoot into/sting/numb into?
____

-Actions affecting this symptom?

	Brings On	Aggravates	Relieves
Bending forward/back	□	□	□
Bending left/right	□	□	□
Twisting left/right	□	□	□
Coughing	□	□	□
Sneezing	□	□	□
Lifting/Straining	□	□	□
Standing	□	□	□
Sitting	□	□	□

Please mark the areas of pain on the figures below





-How bad is your pain? (indicate 0 no pain to 10 unbearable)
0--------------------------------5---------------------------------10

-When is the pain at its worse?
□ Morning □ Afternoon □ Evening □ Bedtime

Patient / Parent Signature:____ Date:__________________________

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

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME: ____ **DATE:** ________________

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment:____

3. Do your hands or arms fall asleep regularly? NO YES
   Comment:____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ____

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ____

8. Do your legs or feet fall asleep regularly? NO YES
   Comment: ____

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: ____

10. Do you suffer from cold hands or feet? NO YES
    Comment: ____

11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment: ____

12. Do you have difficulty maintaining your balance? NO YES
    Comment: ____

13. Do you suffer from vertigo or blurred vision? NO YES
    Comment: ____

14. Do you suffer from a reduced hearing capacity? NO YES
    Comment ____:

15. Do you suffer from ringing in your ears? NO YES
    Comment: ____

16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment: ____

Patient / Parent Signature:________________________________ Date:____________________

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

MEDICAL RECORDS REQUEST

DATE:____

Please list the name of the physician(s) who referred you to us or any physician, person(s), business(s) you would allow us to request or release your personal Health information.

To:____ (primary care physician)

____ (significant other)

____ (attorney/case manager)

____ (other care takers)

I, _________________________ hereby request that my recent medical records be released to:

Kacey Griffin, FNP

BridgeMill Family Healthcare

3755 Sixes Road, Suite 100

Canton, Ga 30114

Office (770)704-4580

Fax (770)704-9142

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at anytime. This consent will automatically expire without my expressed revocation one year from the date on this form.

PATIENT NAME:____

PATIENT ADDRESS:____

PATIENT'S DATE OF BIRTH:____

PATIENT/GUARDIAN SIGNATURE:____

Patient / Parent Signature:____ Date:___________________________

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

PLEASE LIST ALL PREVIOUS TREATMENTS FOR CONDITIONS RELATED TO YOUR CONCERNS

Name ______________________________
Address ____________________________
Phone # ____________________________
Specialty ___________________________
Dates of Care ________________________
Tests/ Treatments _____________________
Results ____________________________

Name ______________________________
Address ____________________________
Phone # ____________________________
Specialty ___________________________
Dates of Care ________________________
Tests/ Treatments _____________________
Results ____________________________

Name ______________________________
Address ____________________________
Phone # ____________________________
Specialty ___________________________
Dates of Care ________________________
Tests/ Treatments _____________________
Results ____________________________

Name ______________________________
Address ____________________________
Phone # ____________________________
Specialty ___________________________
Dates of Care ________________________
Tests/ Treatments _____________________
Results ____________________________

Name ______________________________
Address ____________________________
Phone # ____________________________
Specialty ___________________________
Dates of Care ________________________
Tests/ Treatments _____________________
Results ____________________________

Name ______________________________
Address ____________________________
Phone # ____________________________
Specialty ___________________________
Dates of Care ________________________
Tests/ Treatments _____________________
Results ____________________________

Patient / Parent Signature:_____________________________________ Date:______________________

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

Dear Patient,

We love to send thank you notes for referrals. Please take a moment to let us know how you heard about us.

Thank you! ☺

____

Patient / Parent Signature:____ Date:___________________________

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