12220 Birmingham Hwy, Suite 40
Milton, Ga 30004
770-777-2377
770-777-2527 (Fax)
info@alphaspinecenter.com

PLEASE FILL OUT THE INFORMATION BEFORE COMING INTO YOUR FIRST VISIT TO THE ALPHA SPINECENTER. MAKE SURE YOU FILL IN EVERY BLANK SO WE CAN TAKE THE BEST CARE OF YOU. USE A BLACK OR BLUE PEN.

PATIENT INFORMATION

Patient First Name_____ Middle In. _____ Last _____

Nickname _____

Address_____City_____State____

_____Zip_____

Phone: Home _____ Work _____

Cell_____

Social Security# _____ EMAIL_____ DOB

_____ Age_____

Employer _____ Marital Status S M W D

Number Children _____

Employer Address _____ Occupation

_____ Years on Job _____

Spouse/Guardian First _____Middle_____ Last

_____

SS# _____ Spouse DOB _____ Emergency

Contact#_____

Spouse Employer _____ Work Phone_____

Insurance_____

SpEmployAddress _____ City _____ State_____ Zip _____

Occupation _____

Referred By _____

If Medicare Patient:

Medicare # _____

If an auto accident:

Was your injury caused by an auto accident? _____Yes _____ No

What date was the auto accident? _____/_____/_____

Was it your fault? _____ Yes _____ No

FEES FOR SERVICES RENDERED: There is no fee for consulting with the doctor. Fees begin when a spinal or spine related problem is found and you decide you want us to take care of it for you.

Signature _____ Date:_____

FAX OR EMAIL THESE FORMS BACK TO US 24 HOURS BEFORE YOUR APPOINTMENT TIME.

Health History

Name: _____ **Patient File#**_____ **Date:** _____

Please mark the "Present" column for all additional health complaints or concerns that you have at this time. Please mark the "Past" column for any conditions that you have previously had. Please mark the "Family" column for any chronic or significant conditions that an immediate family member has had at any time.

Present	Past	Family		Present	Past	Family		Present	Past	Family	
☐	☐	☐	Headache	☐	☐	☐	Fatigue	☐	☐	☐	Night Sweats
☐	☐	☐	Neck Pain	☐	☐	☐	Fainting	☐	☐	☐	Flushed Face
☐	☐	☐	Jaw Pain	☐	☐	☐	Convulsions	☐	☐	☐	Cold Hands
☐	☐	☐	Neck Stiffness	☐	☐	☐	Pins & Needles Feelings	☐	☐	☐	Cold Feet
☐	☐	☐	Neck Motion Restriction	☐	☐	☐	Tingling Sensations	☐	☐	☐	Irritability
☐	☐	☐	Loss of Balance	☐	☐	☐	Shoulder Pain	☐	☐	☐	Anxiety
☐	☐	☐	Loss of Smell	☐	☐	☐	Arm or Hand Pain	☐	☐	☐	Depression
☐	☐	☐	Loss of Taste	☐	☐	☐	Leg or Foot Pain	☐	☐	☐	Dizziness
☐	☐	☐	Loss of Concentration	☐	☐	☐	Varicose Veins	☐	☐	☐	Ringing in Ears
☐	☐	☐	Vision Problems	☐	☐	☐	Dental Problems	☐	☐	☐	Insomnia
☐	☐	☐	Sinus Trouble	☐	☐	☐	Difficulty Swallowing	☐	☐	☐	Nervousness
☐	☐	☐	Hearing Loss	☐	☐	☐	Abnormal weight gain/loss	☐	☐	☐	Numbness
☐	☐	☐	Memory Loss	☐	☐	☐	Loss of Appetite	☐	☐	☐	Allergies
☐	☐	☐	Heavy Feeling of Head	☐	☐	☐	Indigestion/Heartburn	☐	☐	☐	Alzheimer's
☐	☐	☐	Eyes Sensitive to Light	☐	☐	☐	Nausea	☐	☐	☐	Anemia
☐	☐	☐	Pain Behind Eyes	☐	☐	☐	Vomiting	☐	☐	☐	Anorexia
☐	☐	☐	Persistent Cough	☐	☐	☐	Abdominal Pain	☐	☐	☐	Arthritis
☐	☐	☐	Upper Back Pain/Stiffness	☐	☐	☐	Gallstones	☐	☐	☐	Asthma
☐	☐	☐	Mid Back Pain/Stiffness	☐	☐	☐	Liver Disorder	☐	☐	☐	Cancer
☐	☐	☐	Low Back Pain/Stiffness	☐	☐	☐	Flatulence (Gas)	☐	☐	☐	Diabetes
☐	☐	☐	Joint Swelling/Stiffness	☐	☐	☐	Ulcer	☐	☐	☐	Emphysema
☐	☐	☐	Coordination Problems	☐	☐	☐	Colitis	☐	☐	☐	Epilepsy
☐	☐	☐	Chest Pain	☐	☐	☐	Diarrhea	☐	☐	☐	Gout
☐	☐	☐	Palpitations	☐	☐	☐	Constipation	☐	☐	☐	Hepatitis
☐	☐	☐	Angina/Heart Attack	☐	☐	☐	Frequent Urination	☐	☐	☐	HIV (AIDS)
☐	☐	☐	Aneurysm	☐	☐	☐	Painful Urination	☐	☐	☐	Lupus
☐	☐	☐	Blood Disorder	☐	☐	☐	Loss of Bladder Control	☐	☐	☐	Migraines
☐	☐	☐	High Blood Pressure	☐	☐	☐	Kidney Stones	☐	☐	☐	Stroke
☐	☐	☐	Dermatitis/Eczema/Rash	☐	☐	☐	Kidney Disorder	☐	☐	☐	Tuberculosis
☐	☐	☐	Drug/Alcohol Dependence	☐	☐	☐	Kidney Infection	☐	☐	☐	Shortness of Breath
☐	☐	☐	Mental Illness	☐	☐	☐	Prostate Problems	☐	☐	☐	Loss of conscness
☐	☐	☐	Excess Perspiration	☐	☐	☐	_____	☐	☐	☐	_____
☐	☐	☐	Excessive Thirst	☐	☐	☐	_____	☐	☐	☐	_____

How often do you exercise? ☐ Daily

Exercise:

☐ A few times a week
☐ A few times a month
☐ Occasionally ☐ Never Is your exercise: ☐ Strenuous ☐ Moderate ☐ Light

Habits:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Caffeinated Soda	☐	☐	☐	☐
Drug Use	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Does it affect your condition? Yes ☐☐ No **Mattress Age:** ___ **Referred By:** _____

Alpha Spine Center
gentle proven care.

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes documents for those services.

Example of Uses of Your Health Information for Treatment Purposes:
Our staff obtains treatment information about you and records it in your health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of Use of Your Health Information for Payment Purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights:
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted.
2. Obtain a copy of this Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.
3. Request that you be allowed to inspect and copy your health record and billing record - you may exercise this right by delivering the request in writing to our office.
4. Appeal a denial of access to your protected health information except in certain circumstances.
5. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
6. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
7. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to your or made at your request, or disclosures made to family members or friends in the course of providing care.
8. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.
9. Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office manager, in person or in writing, during normal business hours. They will provide you with assistance on the steps to take to exercise your rights.

You have a right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and heath care operations purposes.

Our Responsibilities as a Chiropractic Practice:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office manager (our designated HIPAA internal contact person). Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our office manager. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses
Our Office Open Setting: Please be advised that we operate in an open setting. We make every effort to hold sensitive *personal and* confidential information private. During routine visits others may over hear conversations such as recommendations for treatment. If you have any concerns of this method of practice, please make your concerns known to the doctors. If you have something that needs more privacy, please ask the doctor before the patient exam of your need so that the conversation can be moved to the doctor's office or a private room.
Notification: Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
Reminders: Unless you object, we will use reminder postcards to remind you about longstanding or missed appointments.
Communication with Family: Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.
Public Health: As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Abuse & Neglect: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution or its agents your protected health information necessary for you health and the health and safety of other individuals.
Law Enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.
Health Oversight: Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.
Judicial/Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.
Other Uses: Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.
Website: If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date of This Notice: April 1, 2003

Patient File #: _____

I, _____ hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature:_____

Print Name:_____Date:_____

Alpha Spine Center 12220 Birmingham Highway
Milton, GA 30004-4184 (770) 777-2377 (770) 777-2527

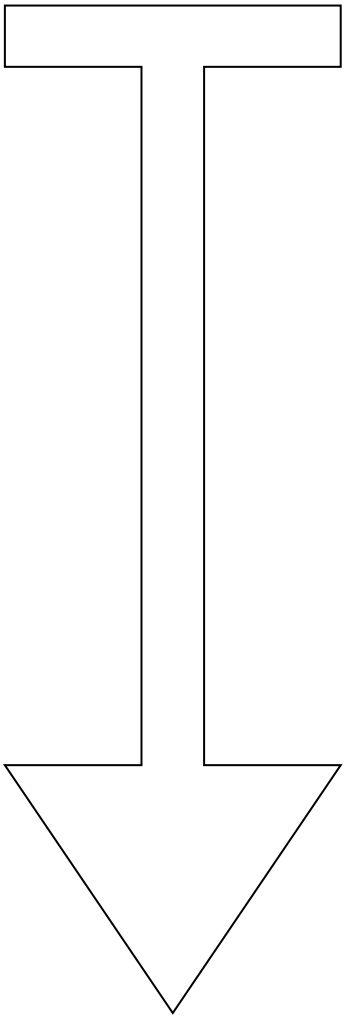
INSTRUCTIONS FOR THE NEXT TWO FORMS:

FORM1: NECK PAIN DISABILITY INDEX
FORM2: OSWESTRY LOW BACK PAIN SCALE

IN THE FIRST BLOCK LABELED 0-10 ON EACH FORM PLEASE CIRCLE THE PAIN LEVEL YOU ARE HAVING 10 IS THE WORST PAIN, 0 IS NO PAIN.

IN THE SECTIONS 1 -10 TO FOLLOW CIRCLE THE BEST FIT ANSWER FOR EACH SECTION. EVEN IF IT DOESN'T APPLY TO YOU 100%, SELECT THE BEST FIT ANSWER.

ONCE YOU HAVE FINISHED ALL 10 SECTIONS ADD UP THE NUMBERS AND TOTAL IT IN THE TOTAL_____ BOX.



Name: _____ File# _____ Date:_____

Neck Pain Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to Manage in everyday life. Please mark the **ONE NUMBER** in each section which most closely describes your problem. We realize you may consider that two of the statements in any one section relate to you, but only mark the box which most closely describes your problem.

Section 1- Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2- Personal Care (Washing, Dressing, etc.)

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dresses, I wash with difficulty and stay in bed.

Section 3- Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
3. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I do not get dressed, I wash with difficulty and stay in bed.

Section 4-Reading

0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want to with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I can't read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all.

Section 5- Headaches

0. I have no headaches at all.
1. I have slight headaches which come in-frequently.
2. I have moderate headaches which come in-frequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

Section 6- Concentration

0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7- Work

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I can't do any work at all.

Section 8- Driving

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I can't drive my car as long as I want because of slight pain in my neck.
4. I can't drive my car as long as I want because of moderate pain in my neck.
5. I can't drive my car at all because of the pain.

Section 9- Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1hr. sleepless).
2. My sleep is mildly disturbed (1-2 hrs. sleepless).
3. My sleep is moderately disturbed (2-3 hrs. sleepless).
4. My sleep is greatly disturbed (3-5 hrs. sleepless).
5. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10-Recreation

0. I am able to engage in all my recreation activities with no neck pain at all.
1. I am able to engage in all my recreation activities with some pain in my neck.
2. I am able to engage in most, but not all my recreation activities with some pain in my neck.
3. I am able to engage in a few of my usual recreation activities because of pain in my neck.
4. I can hardly do any recreation activities because of pain in my neck.
5. I can't do any recreation activities at all because of pain in my neck.

TOTAL_____

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***

Name: _____ File# _____ Date:_____

Oswestry Low Back Pain Scale

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1- Pain Intensity
0. The pain comes and goes and is very mild
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate
3. The pain comes and goes and does not vary much.
4. The pain comes and goes and is severe
5. The pain is severe and does not vary much

Section 2- Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3- Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4-Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk without increasing pain.

Section 5- Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting for than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6- Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7- Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by les than one –quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8- Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9-Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10- Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL_____

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***