

**Northside Office**  
 980 Johnson Ferry Road, NE  
 Suite 1000  
 Atlanta, GA 30342  
 404-255-1242



**Alpharetta Office**  
 3400A Old Milton Parkway  
 Suite 350  
 Alpharetta, GA 30005  
 404-639-9098

## Health History

Patient Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Surgery:  Yes  No Date of Surgery: \_\_\_\_\_

Are you allergic to ANY medications?  Yes  No If yes, indicate type(s):

Are you taking Prescription or Non-Prescription medications for this injury/condition?  Yes  No

Are you currently taking any of the following:	Yes	No	If Yes, indicate type(s)
Anti-Inflammatories			
Muscle Relaxers			
Pain Medication			

Have you ever had any of the following medical or rehabilitative services for this injury:	Yes	No
Chiropractor		
Occupational Therapy		
Massage Therapy		
Physical Therapy		

Do you have any of the following:	Yes	No	Do you have any of the following:	Yes	No
Asthma, Bronchitis, Emphysema			Severe or Frequent Headaches		
Shortness of Breath / Chest Pain			Vision or Hearing Difficulties		
Coronary Heart Disease / Angina			Numbness or Tingling		
Pacemaker			Osteoporosis		
High Blood Pressure			Gout		
Stroke / TIA			Sleeping Problems or Difficulties		
Blood Clot / Emboli			Emotional / Psychological Problems		
Epilepsy / Seizure			Bowel / Bladder Problems		
Thyroid Trouble / Goiter			Dizziness or Fainting		
Anemia			Weakness		
Infectious Disease			Weight Loss / Energy Loss		
Diabetes			Hernia		
Cancer / Chemotherapy / Radiation			Varicose Veins		
Arthritis / Swollen Joints			Allergies		
Neck Injury / Surgery			Joint Replacements		
Do you smoke?			Any Pins / Implants		
Are you pregnant?			Other? Explain below		

Please list any other information that would assist us in your care:

\_\_\_\_\_

Signature of Patient, Guardian or Responsible Party

Date