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			Massage Therapy		
Occupational 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