Emmad Chiropractic LLC.

Welcome to Emmad Chiropractic clinic where we are committed to "maintaining a lifetime of wellness" to all civilians around Gwinnett County and in the Atlanta area.

Allow us to sincerely thank you for selecting us as your personal family Chiropractor. We look forward to partnering with you to address your health concerns, and we will do all we can to ensure you achieve the most successful result possible for you. Our staff will listen with an attentive ear and will do whatever we can to ease your journey through what can be a very difficult time.

The trust and confidence you have placed in us is most appreciated. Our mission is to help you achieve your treatment goals, and to maintain optimal health over the long-term using safe, natural and holistic approach, and nutritional guidance and support. Chiropractic adjustments definitely works. The precious gift of health is an investment that takes both time and money.

In order to help you to get the most out of this worthwhile investment We would like to share a few suggestions:

1. Be on time and keep your appointments. Each treatment builds upon previous ones. It is important to follow through with your future care plan in order to receive maximum benefit.

2. Do your homework. In many ways what you do at home, at work and at play affects your progress. We offer suggestions and self-care techniques to support you on the road to your treatment goals toward a life of increased wellness and vitality.

3. Give it time. As with any medical treatment, healing with chiropractic adjustment is a process, not a magic pill. It takes time and is influenced by many factors. Over time, things should improve and if necessary, we will adjust your treatment plan as we proceed. Changes to your condition can happen faster than anticipated, so enjoy them!

4. Keep a positive attitude and EXPECT positive results. As we follow through on your treatment plan, look for signs of improvement and take encouragement from them. Build an attitude that expects positive results and knows that profound healing is possible. Your belief and expectation has an incredibly strong influence on your body, and is a key factor in healing.

It is a great pleasure to welcome you to the clinic!

If at any time you have any questions, or if you should require our assistance in any way, please do not hesitate to call our office. We will respond as quickly as possible.

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(If applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

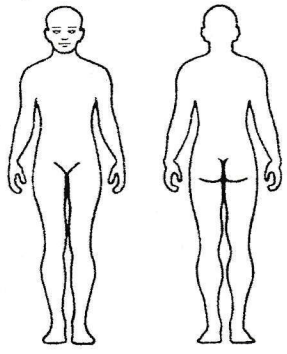
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date_____

PAIN ASSESSMENT: [_] Initial [_] Re-Assessment

[_]Head
[_]Neck
[_]Upper Back
[_]Right Shoulder
[_]Left Shoulder
[_]Right Elbow
[_]Left Elbow
[_]Right Hand/Wrist
[_]Left Hand/Wrist

[_]**Pain** is:
[_]Constant
[_]Intermittent
[_]Occasional
[_]Seldom
[_]Never

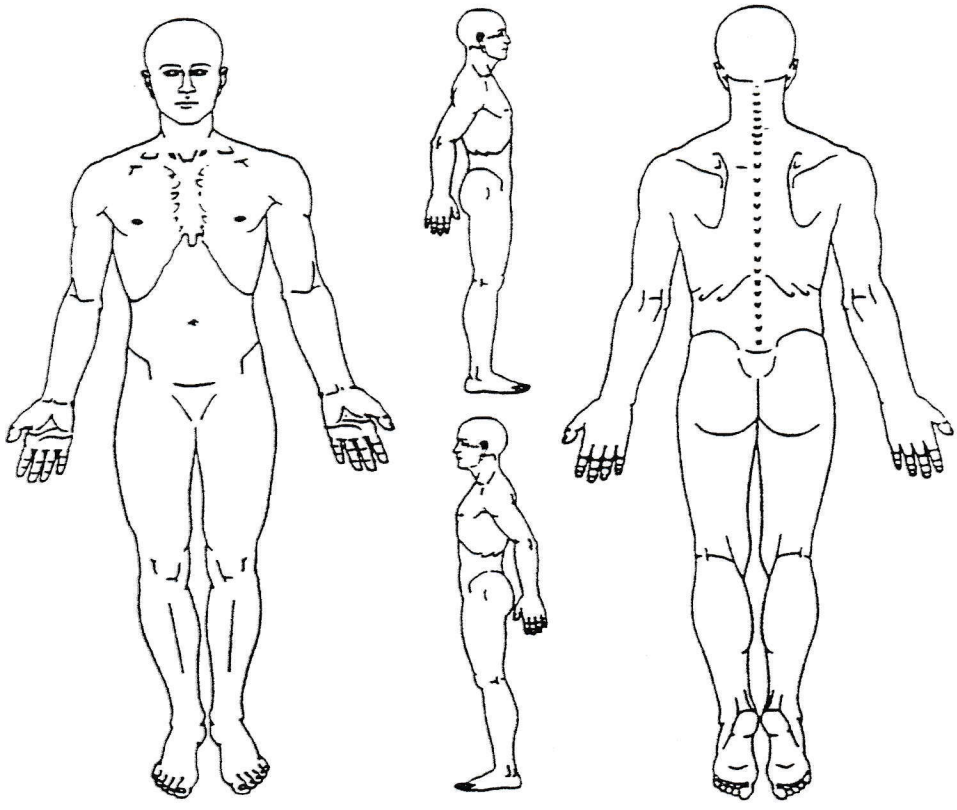
[_]**Numbness/Tingling** is:
[_]Constant
[_]Intermittent
[_]Occasional
[_]Seldom
[_]Never

Pain **Increases**?
[_]With Movement
[_]With Activity
[_]With turning of Head
[_]When looking Up
[_]When Looking Down
[_]When I Twist to Right
[_]When I Twist to Left
[_]When Using My Arms
[_]When Using My Right Arm
[_]When Using My Left Arm
[_]When Gripping
[_]In the Morning
[_]In the Afternoon/Evening
[_]When Driving/Riding
[_]When I Cough
[_]When I Sneeze
[_]When I have a Bowel Movement
[_]With Cold/Rainy Weather

Pain **Decreases**?
[_]When I rest
[_]With Inactivity
[_]With Treatment
[_]With Medication
[_]With 'Working it Out'

Condition is:
[_]Acute

[_]Chronic



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Emmad Chiropractic

HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____ SS#: _____
Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES Emmad Chiropractic TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Emmad Chiropractic to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, internal referral board, sign in sheet, travel cards or fee slips, information about treatment alternatives or other health related activities.
- If Emmad Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give Emmad Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations. If I invite a friend or relative to enter the treatment room, I authorize the doctor to talk about my treatment in their presence.
- By signing this form you are giving Emmad Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above including allowing a new doctor to have access to my files if the clinic is sold.

EXPIRATION

The Authorization shall expire on the following date: _____.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken actions in reliance on your authorization.
You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the privacy official of Goren Clinic. The written notice must contain the following information:

Your name, Social Security number and date of birth; **a clear statement of you intent to revoke this AUTHORIZATION; the date of your request; and your signature.**

The revocation is not effective until received by the Privacy Official.

This AUTHORIZATION is requested by Emmad Chiropractic for its own use/disclosure of PHI. *(Minimum standards apply).*

You have the right to refuse to sign this ATHORIZATION. If you refuse to sign this AUTHORIZATION, Goren Clinic will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

_____ _____
Print Name of Patient Signature of Patient

_____ _____
Signature of personal Representative Date

Description of Representative's Authority to Act for Patient: