Welcome To Titus Family Chiropractic

Dr. Todd Titus

Our Goals:

1. Find the cause of your pain and reduce any symptoms as soon as possible.
2. Provide specific home instructions and exercises to help reduce future injury.
3. Give outstanding customer service with compassion and honesty.

Most patients respond to care in 4 to 6 visits. It is very important that you follow all of the doctor's recommendations, this will allow for optimal healing. *Please communicate with us immediately if you have any questions or concerns. We specialize in treatment involving many conditions but this is not a medical clinic. It is important for you to see your medical practitioner as soon as possible to check you for any medical problems. If you need one, please ask us for a referral. We are a chiropractic (done by hand) clinic focusing on the musculoskeletal system which protects the related neurological system. We will perform a detailed neurological & orthopedic physical exam to determine if we can help you. Further tests may include X-ray, MRI, or CT scan. Treatment may include Active Release Technique, massage, laser therapy and spinal adjustments. If you are not improving or your condition is worsening, a referral to the proper specialist or diagnostic test will be made. **It is always a good idea to communicate with all your doctors. Please list any doctors you would like us to send reports to.**

Doctor: _____ # _____ Doctor: _____ # _____

Confidential Patient Information

Name _____ Date / / Social Sec. Number _____

Date of Birth _____ Age _____ Gender M or F Marital Status _____ # Children ___

Address _____ (Address) (City) (State) (Zip Code)

Home Phone # _____ Cell _____ Email _____

Work _____ (Your Occupation) (Company Name) (Work Phone)

How did you hear about us? _____

Payment Options: Cash—Check—Credit Card—Health Insurance—Auto Insurance

Have You Been in an Auto/Work Accident?—Past Yr—Past 5 Yrs—Over 5 Yrs—Never

Health Insurance Information:

Please give all insurance cards to the receptionist so that we can make copies to verify coverage.
IF THIS IS DUE TO A WORK OR AUTO INJURY PLEASE STOP HERE YOU HAVE THE WRONG FORMS

Primary insurance: _____ Secondary insurance: _____

Financial Agreement

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment; any fee for professional services rendered me will be immediately due and payable.

Notice: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

*Insurance Cases: Deductible should be met in the beginning unless prior arrangements are made.

***I hereby agree that if my bill has to be turned over to a third party collection agency for non-payment, there will be a collection fee added to my bill of 30% this is pursuant to Georgia Statutory Law "O.C.G.A.-13-1-11".

Patient or Guardian Signature _____ Date / / .

PERSONAL HEALTH HISTORY - Please read through the list and check any condition that applies to you.

Social History
- ☐ Alcohol (drinks a day ____)
- ☐ Tobacco (packs a day ____)
- ☐ Other _____.

GENERAL CURRENT CONDITIONS
- ☐ Recent accident such as a fall, whiplash, or blow to the head
- ☐ Muscle spasms
- ☐ Numbness/ Tingling - Hands/ Feet
- ☐ Headaches
- ☐ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Dizziness
- ☐ Vision problem
- ☐ Nausea
- ☐ Restriction of movement
- ☐ Sleeping trouble
- ☐ Asthma or breathing problem
- ☐ High blood pressure
- ☐ Hearing problem
- ☐ Convulsions/epilepsy
- ☐ Heartburn/Acid Reflux
- ☐ Digestive troubles
- ☐ Menstrual problems
- ☐ Spinal disorders
- ☐ Shoulder, arm or hand problems
- ☐ Hip, Leg or foot problem
- ☐ Sinus problems
- ☐ Difficulty with stress
- ☐ Chest pain
- ☐ Arm or leg pain
- ☐ Constipation
- ☐ Jaw/mouth/TMJ problems

DIAGNOSED CONDITIONS
- ☐ Bone or joint disorders
- ☐ Disc herniations
- ☐ Degenerative arthritis
- ☐ Rheumatoid arthritis
- ☐ Subluxations
- ☐ Sprains
- ☐ Fibromyalgia
- ☐ Compression fracture
- ☐ Torn muscles
- ☐ Heart attack or heart disorder
- ☐ History of stroke or aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ AIDS
- ☐ RSD
- ☐ Tuberculosis
- ☐ Hepatitis B or HIV infection
- ☐ Multiple sclerosis
- ☐ Mental illness
- ☐ Thyroid or hormone disorder

OTHER HEALTH CONDITIONS
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

SPECIFIC PAIN IN THE BODY
- ☐ Difficulty swallowing due to pain
- ☐ Extreme stiffness
- ☐ Pain only during motion
- ☐ Area feels too heavy to hold up
- ☐ Sitting makes pain worse
- ☐ Coughing or sneezing makes worse
- ☐ Leg pain that worsens with exercise
- ☐ Numbness in thighs or buttocks
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Bruises / bleeding with no trauma
- ☐ Constant pain that doesn't improve by changing positions or by lying down
- ☐ Hands and feet cold
- ☐ Loss of feeling any area

SPECIFIC CURRENT CONDITIONS
- ☐ Poor balance
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Memory loss after injury
- ☐ Recent, unexplained weight loss
- ☐ Recent progressive muscle weakness, muscle loss or shaking
- ☐ Recent fever over 102°F
- ☐ Have you loss consciousness
- ☐ Slurred speech
- ☐ Poor circulation
- ☐ Blood in urine
- ☐ Growths or masses
- ☐ Loss of bowel or bladder control

PAST / OTHER MEDICAL HISTORY				
FAMILY MEMBER'S HISTORY	Similar problems?			
	Disability	Yes	No	If yes, who?
	Arthritis	Yes	No	If yes, who?
	Heart Disease	Yes	No	If yes, who?
	Diabetes	Yes	No	If yes, who?
	Other?	Yes	No	If yes, who?
		Yes	No	If yes, who?
		Yes	No	If yes, who?
Have you ever had an MRI, X-ray or CT scan?		Yes	No	If yes, results?
HOSPITALIZATIONS	Year	Illness/Operation		Remaining problems
PREVIOUS TRAUMA (Automobile accident, fractures, strains, any other)	Date	Injury/Accident		Remaining problems
ALLERGIES (medications or environmental)				
MEDICATIONS (please all medications you take—even if only occasionally)	Medication	Dose	How Often	When Started / Why?

INFORMED CONSENT, HIPPA & OFFICE POLICIES - CONTRACT

*Please read & initial each box then sign below

Doctor Patient

☐ ☐ I have been informed that it is not uncommon for patients have increased discomfort after therapy. If that happens I will apply ice to the area & rest it. If I am concerned about this discomfort or develop any new symptoms I should call the office as soon as possible. If needed I should present myself to an emergency room or call 911. Treatment is hands on or by machine and with any procedure there are risks and side effects possible. Communication is essential, if I am uncomfortable or concerned about any procedure or have side effects I am to stop the procedure immediately and tell the doctor immediately.

☐ ☐ I understand that this is a corporation. I will not hold liable, & in fact release & discharge all liability to any individual, doctor, employee, staff member, stockholder or corporate officers. I will honor this corporate structure at all times. I understand that results are not guaranteed.

☐ ☐ I hereby request & consent to examination, chiropractic & other procedures, including various modes of physical therapy, massage &, if necessary, diagnostic x-rays, on me by this clinic. Our scope of practice and training does not include the treatment, evaluation or diagnosis of cancer, fractures, tumors, organ pathology, diabetes, vascular, or any medical related pathology. I am advised to speak with my medical doctor about all conditions. I further understand that x-rays are not good for an unborn child. By signing here I certify that I am not pregnant or do not think I am may be pregnant.

☐ ☐ I understand & am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle strains /sprains, fractures, disc injuries, & strokes. I do not expect the doctor to be able to anticipate & explain all risks, alternatives & complications, I wish to rely on the doctor to exercise judgment which the doctor feels is best at the time, based upon the facts then known.

☐ ☐ I hereby authorize you, your employees & agents to furnish anyone designated in writing by them, all copies of records & reports, concerning any condition that I may have had in the past, now have, or may have in the future. I give permission to use my address, phone number & clinical records to contact me with appointment reminders, missed appointment notification, phone messages, emails, birthday cards, holiday related cards, information about our clinic, or other health related information. I can revoke this authorization at anytime in written form. All of my records will be protected & will not be released to others without my consent.

☐ ☐ Initials

I am responsible for this account. I direct any insurance company, attorney or other person who holds or later holds proceeds to apply it to my account at this clinic, as payment toward the total charges for professional services rendered. I agree to pay, in a current manner, any balances of said applicable charges. I agree that this office be given power of attorney to endorse any and all drafts for payment of my bill. All co pays and deductibles are due at the time of service. I understand that I will be responsible for any collection or court fees involved if the account has to be sent to collections. I also certify that I am not using a false identity or someone else's identity.

I understand that all of the above is legally binding and that this contract can only be modified by addendum signed by both parties. If I do not understand or agree with any of the above I will discuss this with the doctor. I will not sign below if I do not understand or agree to fully honor this agreement. I also intend that this agreement is permanent, irrevocable and binding on my heirs and assigns. I have read, understand and agree to all of the above.

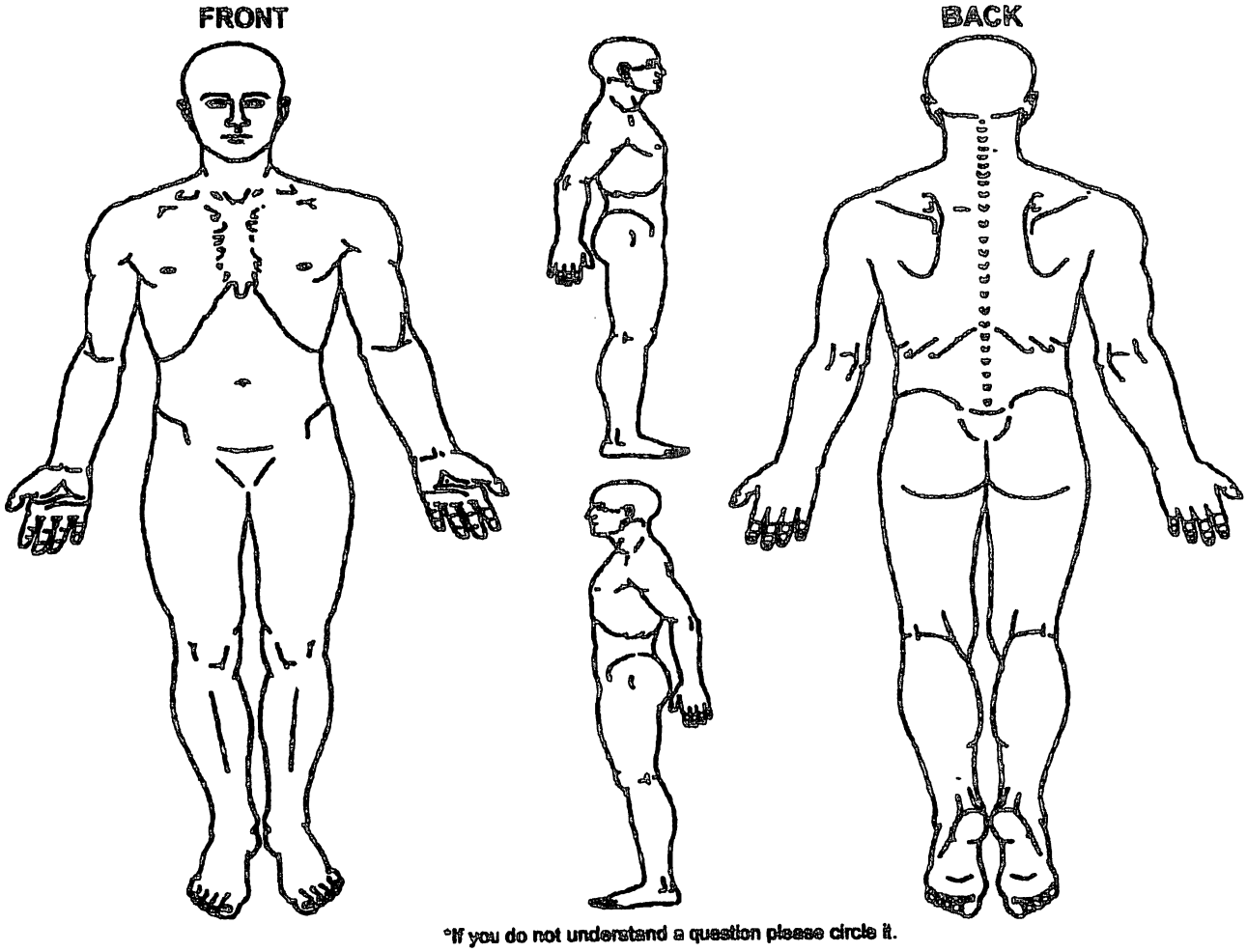
_____

Print Patient's Name Signature of Patient (or parent/guardian) Date

Doctor Signature: _____ Date: _____

PAIN DIAGRAM

Label : A=Aching, B=Burning, N=Numbness, SH=Shooting Pain, ST=Stabbing, T=Tingling, O= Other



*If you do not understand a question please circle it.

CURRENTLY (Subjective)

Check the box (X) that describes:	0 None	1-2 Mild (mild)	3-4 Uncomfortable (moderate)	5-6 Distressing (fairly severe)	7-8 Very severe (horrible)	9-10 Unbearable
Neck pain						
Middle back pain						
Lower back pain						
Headaches						
Other:						

Please describe your current symptom: _____

Is your condition constant, frequent, occasional or on & off? _____

Is your condition getting worse, improving or staying the same? _____

Have you ever had these problems before? _____

What do you think caused your condition? _____

Is there anything else that you want to say about your condition? _____

Have you seen any other physicians for this condition (Diagnosis)? _____