2425 W. Broad Street
Athens, Georgia 30606
706-543-2584 * Fax: 706-354-0702
Email: grandoakhealthcare@gmail.com

GRAND OAK HEALTHCARE
SPINAL CARE - OCCUPATIONAL MEDICINE

3900 Hwy 81 S.
Loganville, Georgia 30052
770-687-2655 * Fax: 770-687-2655
Email:grandoakhealthcarelv@gmail.com

Website: www.mygrandoak.com

Name: _____ Birthdate: ___/___/____ Sex: Male _____ Female _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell#: _____

Email: _____ S.S.N.: _____

Preferred method of communication for office appointments: Text_____ Email _____

Marital Status: Married ____ Divorced ____ Single ____

Occupation: _____ Employer: _____ Yrs Employed: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

Spouse's Name: _____ Occupation: _____ Employer: _____

Emergency Contact and Phone Number: _____

Insurance Provider: _____ Subscriber/Member #: _____

What is your chief complaint: _____

Cause of condition: _____

Have you had similar conditions in the past? Yes ☐ No ☐

How did you hear about us? _____

ACCIDENT INFORMATION ***Notify Front Desk of Auto Medpay Benefits***

Did your accident occur while at work? Yes ☐ No ☐ Injury Reported to Employer? Yes ☐ No ☐

Were you involved in an automobile accident? Yes ☐ No ☐ Date: _____ Time: _____

I clearly understand that all services rendered to me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered to me will be immediately due & payable.

Patient Signature: _____ **Date:** _____

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Health History Form

Name _____

Age _____ Date of birth _____ Sex _____

Occupation _____

Patient's Chief Complaint _____

Medications (List all medications you are currently taking.)		Allergies (List all allergies)

Patient's Past History:

Do you have or have you ever had the following? Check each box that is answered "yes".

- ☐ Headaches, dizziness, fainting
- ☐ Blurred vision
- ☐ Sinus trouble
- ☐ Asthma
- ☐ Sore throats
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Night sweats
- ☐ Arthritis
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heartburn or indigestion
- ☐ Nausea and/or vomiting
- ☐ Stroke
- ☐ Ringing in Ears
- ☐ Sudden weight gain or loss
- ☐ Kidney disease or stones
- ☐ Painful and/or difficult nutrition
- ☐ Become tired or upset easily
- ☐ Depression
- ☐ Convulsions
- ☐ Back pain or injury
- ☐ Diabetes
- ☐ Prior spinal surgeries

Please use the space below to explain any "yes" answers.

Serious Illness/Injuries/Hospitalizations	**Date**	**Outcome**

Patient's Family and Social History:

	Yes	No	Amount/How Often
Do you use tobacco?	○	○	_____
Do you use drugs?	○	○	_____
Do you use alcohol?	○	○	_____
Do you exercise regularly?	○	○	_____

	Age	**State of Health**	**Serious Illness and/or Cause of Death**
Father			
Mother			
Brother			
Sister			

Patient Signature: _____ **Date:** _____