



# UPDATED CONTACT INFORMATION

Le Reve Spinal Care P.C  
Dr. Amir Banishahi B.S, D.C  
1827 Powers Ferry Rd, SE  
Building 7, Suite 150  
Atlanta, GA 30339  
Tel: (678) 401-3803

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Age  
Gender  Male  Female

Race  
 American Indian  Alaskan Native  Asian  Black or African American  
 Native Hawaiian  Other Pacific Islander  Other  White  
 Decline to answer

Ethnicity  
 Hispanic or Latino  
 Not Hispanic or Latino  
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

- Never A Smoker  Former Smoker
- Current Every Day Smoker  Current Some Day Smoker
- Heavy Smoker  Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status  Married

Single  Divorced

Widowed  Separated

Preferred Language

City

State/Province

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

- Yes  No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone

Work Phone  Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

- Self  Spouse  Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

I certify that any changes to my personal information have been updated above for your records.

Signature

I have new contact information

Today's Date (MM/DD/YYYY)

Patient Number  
(office use only)

Your Last Name

Your First Name

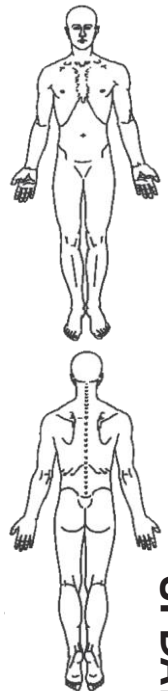
Your Middle Name (or Initial)

Please select one:

- Progress evaluation** – I've been under active care and this is a periodic reevaluation.       **New condition** – I've been under care and a new or returning condition has emerged.
- Maintenance patient** – I'm under maintenance care with a new or returning health issue.       **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

**Location**  
(Where does it hurt?)  
Circle the area(s) on the illustration.  
"O" for current condition  
"X" for conditions experienced in the past



1. Review of systems (Identify any changes since your most recent evaluation with us):

- |   | Worse                 | No Change             | Improved              |
|---|-----------------------|-----------------------|-----------------------|
| a. <b>Musculoskeletal System</b> – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. <b>Neurological System</b> – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. <b>Cardiovascular System</b> – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. <b>Respiratory System</b> – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. <b>Digestive System</b> – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. <b>Sensory System</b> – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. <b>Skin System</b> – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. <b>Endocrine System</b> – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. <b>Genitourinary System</b> – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j. <b>Constitutional System</b> – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Doctor's Initials

2. Illnesses, operations, injuries or treatments since your most recent evaluation with us: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Medications (please list all prescription and over-the-counter): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Social History (Tell Dr. Banishahi about your health habits and stress levels.)

Alcohol use  Daily  Weekly How much? \_\_\_\_\_

Coffee use  Daily  Weekly How much? \_\_\_\_\_

Tobacco use  Daily  Weekly How much? \_\_\_\_\_

Exercising  Daily  Weekly How much? \_\_\_\_\_

Pain relievers  Daily  Weekly How much? \_\_\_\_\_

Soft drinks  Daily  Weekly How much? \_\_\_\_\_

Water intake  Daily  Weekly How much? \_\_\_\_\_

Hobbies: \_\_\_\_\_

Prayer or meditation?  Yes  No

Job pressure/stress?  Yes  No

Financial peace?  Yes  No

Vaccinated?  Yes  No

Mercury fillings?  Yes  No

Recreational drugs?  Yes  No

5. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Is there anything else Dr. Banishahi should know about your current condition, your progress or ways your current condition is affecting your life?

\_\_\_\_\_

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient Number  
(office use only)

Consultation Notes

\_\_\_\_\_  
Patient (or Guardian's) signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Doctor's Initials