GRACE MEDICAL & CHIROPRACTIC

Date:_____

Name:_____ Social Security #_____ Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax # _____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

Emergency Contact:_____ Relation:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Accident Information

Is this due to an accident? _____ If yes what type? ☐ Auto Accident ☐ Worker's Compensation ☐ Other
Has it been reported? _____ If yes to whom? _____

Insurance information: Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other
Policy holder name: _____ DOB _____
Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the physician / medical office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe:_____

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

N = Now P = Previously

Breathing Problems	_____	Weight Loss/Gain	_____

Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

☐ Heart Disease _____ ☐ Headaches _____

☐ Cancer _____ ☐ Low Back Pain _____

☐ Diabetes _____ ☐ Scoliosis _____

☐ Arthritis _____ ☐ Allergies/Asthma _____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

NEUROLOGICAL / VASCULAR QUESTIONNAIRE

NAME _____ **DATE** _____

FOR ANY YES ANSWER, PLEASE INCLUDE DETAILS

Do you suffer from neck pain with pain in your shoulder, arms or hands? ☐ NO ☐ YES

COMMENT: _____

Do you have weakness, numbness or burning in your shoulder/arms/hands? ☐NO ☐ YES
COMMENT: _____

Do your hands or arms fall asleep regularly? ☐NO ☐YES
COMMENT: _____

Do you have reduced feeling/sensation or swelling in your hands or arms? ☐NO ☐YES
COMMENT: _____

Do you suffer from loss of hand grip strength? ☐NO ☐YES
COMMENT: _____

Do you suffer from back pain with pain in your buttocks, legs or feet? ☐NO ☐ YES
COMMENT: _____

Do your legs or feet fall asleep regularly ☐ NO ☐ YES
COMMENT: _____

Do you have reduced feeling/sensation or swelling in your legs or feet? ☐ NO ☐ YES
COMMENT: _____

Do you suffer from cold hands or feet? ☐NO ☐YES
COMMENT: _____

Do you have frequent falls or find that you trip over your feet while walking? ☐NO ☐YES
COMMENT: _____

Do you suffer from headaches? If yes, how often? ☐NO ☐YES
COMMENT: _____

Have you ever been diagnosed by any physician with peripheral neuropathy? ☐NO ☐YES
COMMENT: _____

Have you tried any medication for your pain such as anti-inflammatory or pain medication? ☐NO ☐YES
COMMENT: If yes, what type? _____

Have you tried physical therapy or chiropractic treatment before? ☐NO ☐YES
COMMENT: When, and for how long? _____

Have you had an MRI or any advanced imaging? ☐NO ☐YES
COMMENT: _____

Have you used any splint or braces or other prescribed by an MD? ☐NO ☐YES
COMMENT: _____

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Patients signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of_____and will expire seven years after the date on
Date
which you last received services from us.

_____

Patient Initials

_____ _____

Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

PATIENT NAME: _____ DOB _____

I acknowledge that i have reviewed the notice of privacy practices of Grace Medical and Chiropractic

Please initial one of the following:

_____ I wish to receive a paper copy or privacy practices

_____ I do not wish to receive a paper copy or privacy practices at this time. I acknowledge that I can request a copy at any time.

_____ I acknowledge that it is the policy of Grace Medical and Chiropractic to leave reminder messages on my phone, and to send text messages. I may make a request of alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights I may speak with the Privacy Officer about my concerns.

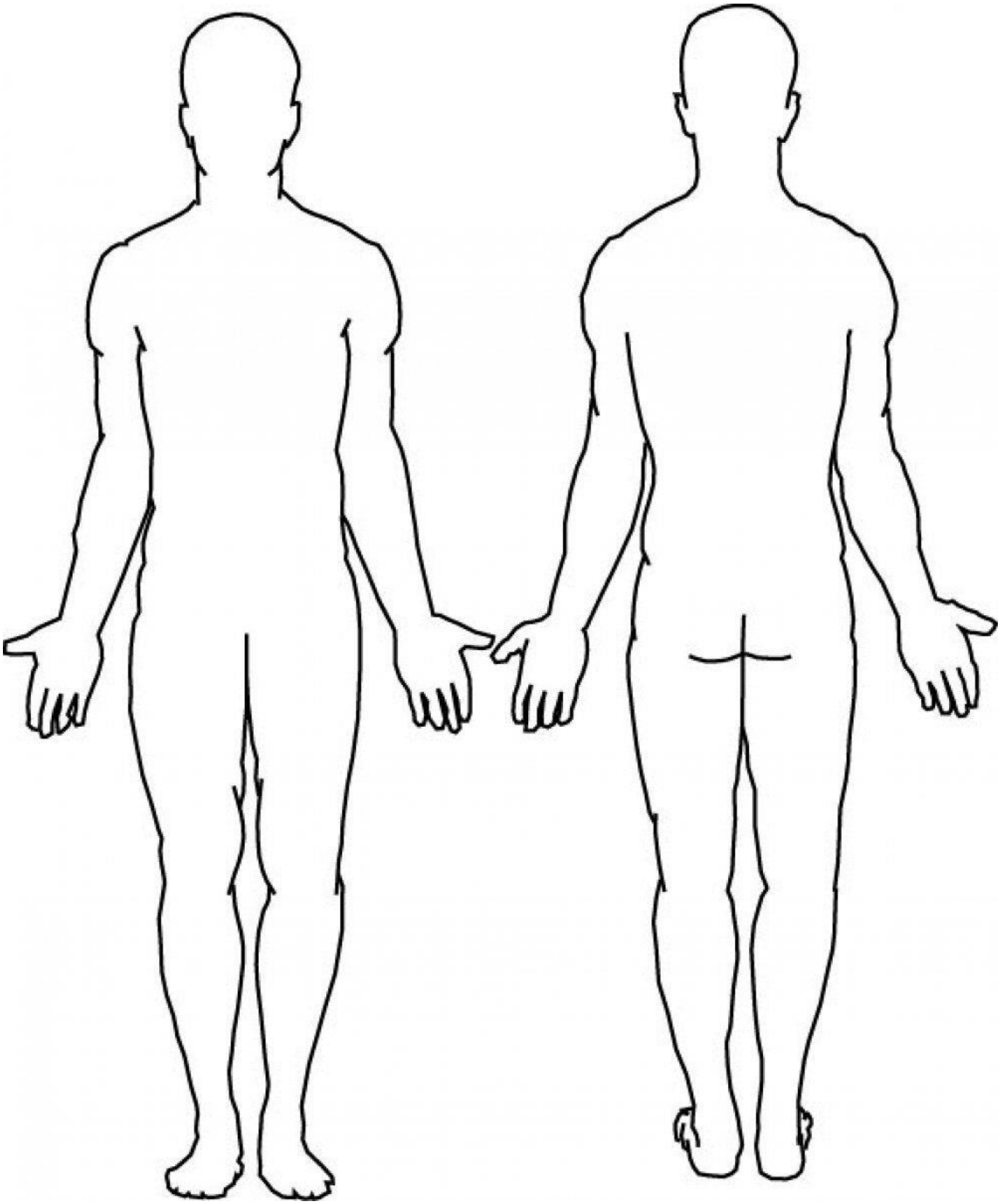
_____ _____

Patient Signature Date

Please give a brief description of what brings you into the clinic today:

BODY MAP

NAME: _____ DATE: _____



XXXX TRIGGER POINT LOCATION
-------- RADIATING PAIN
//////// NUMBNESS AND TINGLING

BURNING PAIN
O JOINT PAIN