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Confidential Patient Information Sheet

Patient Information

Name:____ Date of Birth:______________
Address:____ Apt#:__________
City:__________________________________ State:______________ Zip:________________
Home phone:________________ Work phone:_________________ Cell phone:______________
Preferred contact #: Home/Cell/Work Email:_______________________________________

Height:______ Weight:_______ Age:_______ Sex: □ Male □ Female
Marital Status:___________________________ Number of children:_______________________
Occupation:_____________________________ Employer:____________________________
In case of emergency notify (name and phone number):____________________________________

Primary Care Doctor:____ Last seen:___________
Do we have permission to contact your doctor regarding your treatment in this office? □ Yes □ No

How did you hear about Grayhawk Family Chiropractic? □ Dr.__________ □ Insurance Company
□ Internet Search □ Advertisement □ Patient:_____________________ □ Other:_____________

Insurance Information

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Insured's Name:________________________ Relationship to patient:______________________
Insured's SSN:__________________________ Insured's D.O.B.:____________________________

□ I will not be using insurance. Please note that for our patient's who do not have insurance, or do not wish to use their insurance, we have an affordable time of service discounted fee schedule. Ask us for more details.

My Financial Responsibility

I certify that the above information is correct. I understand that I am personally financially responsible for all services **not** paid for by my insurance. I am also responsible for any annual deductibles applicable, co payments, or non-covered services as may be required by my insurance plan.

____ ____________________
Signature of patient (or person acting on patient's behalf) Date

History of Present Illness

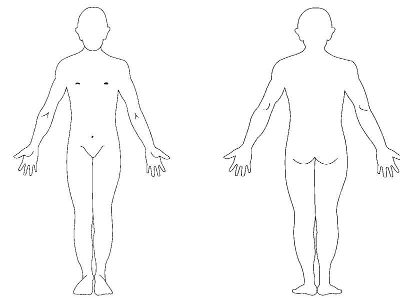
Reason for your visit here today:____
How long have you had this condition?____
How did it start?____
Is this condition a result of an auto-accident or work-injury? □ Yes □ No * If yes, please notify us now*

Are you being treated for this condition by anyone else? □ Yes □ No
If yes, who & type of treatment:____
Have these treatments helped? □ Yes □ Somewhat □ Not much □ Not at all
Have you had chiropractic treatment before? □ Yes □ No
Are you interested in receiving acupuncture treatment as well? □ Yes □ No

How often are you experiencing your symptoms? □ Constantly (76-100% of day) □ Frequently (51-75% of day) □ Occasionally (26-50% of day) □ Intermittently (0-25% of day)

Mark the areas of the body where you feel the described sensations:
---------- Numbness ********* Aching
ooooooo Pins/needles /////////////// Stabbing
xxxxxxx Burning >>>>>>> Other:_________

Please rate your pain on a scale of 1 – 10, with 10 being most severe
Neck/Arm/Shoulder: ______/10
Upper-Mid Back: ______/10
Low Back ______/10
Hip/Leg/Knee/Foot: ______/10



R front L L back R

Does the pain radiate? □ Yes □ No If yes, where:____
Are you currently experiencing pain while coughing/sneezing? □ Yes □ No

My symptoms are currently: □ Getting better □ Getting worse □ Staying same

What helps the pain? □ Ice □ Heat □ Massage □ Rest □ Movement □ Certain positions:__________
□ Pain-reliever □ Nothing □ Other:______________________

What aggravates the pain? □ Pressure to area □ Rest □ Movement □ Certain positions:_____________
□ Nothing □ Other:______________________

During the past 4 weeks how much of the time has your condition interfered with your normal activities:
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

Have you ever had this condition before or a similar condition? □ Yes □ No
If yes: Who did you see for treatment: □ No one □ Chiropractor □ M.D. □ Physical Therapist
□ Other:____

What tests have you received for these symptoms:
□ Xrays Region:_______________ Date:_________
□ MRI Region:_______________ Date:_________
□ CT Region:_______________ Date:_________
□ Other:_____________________________________

In general would you say your overall health is: □ Excellent □ Very Good □ Good □ Fair □ Poor

Medical History

Please check any that you currently have, or have had in the past:

Cardiovascular Conditions:	**Emotional/Mental:**	**Energy & Immunity:**	**Respiratory:**
□ Heart Disease □ Pacemaker □ High blood pressure □ Low blood pressure □ Chest pains □ Palpitations □ Stroke □ Varicose veins □ Edema	□ Clinical depression □ Mild depression □ ADD/ADHD □ Schizophrenia □ Mood swings □ Panic attacks □ Anxiety □ Alzheimers □ Dementia	□ Chronic fatigue □ General fatigue □ Slow wound healing □ Easy bruising □ Chronic infections □ Seasonal allergies	□ Pneumonia □ Asthma □ Frequent colds □ Difficulty breathing □ Emphysema □ Persistent cough □ Pleurisy □ Tuberculosis □ Shortness of breath
Musculo-skeletal: □ Neck/shoulder pain □ Muscle spasms/cramps □ Arm pain □ Upper back pain □ Mid back pain □ Low back pain □ Leg pain □ Osteoporosis/osteopenia □ Arthritis □ Joint pain □ Fractures:____________ □ Dislocations:__________	**Neurological:** □ Vertigo/dizziness □ Paralysis □ Numbness/tingling □ Loss of balance □ Seizures/epilepsy	**Genito-urinary tract:** □ Kidney diseases □ Kidney stones □ Painful urination □ Incontinence □ Difficulty urinating	**Gastro-intestinal:** □ Stomach ulcers □ Changes in appetite □ Nausea/vomiting □ Abdominal pain □ Gall bladder disease □ Constipation □ Diarrhea □ Pain during bowel movements □ Irritable bowel Syndrome (IBS) □ Crohns □ Ulcerative colitis
Endocrine: □ Hypothyroid □ Hypoglycemia □ Hyperthyroid □ Diabetes type I □ Diabetes type II □ Night sweats □ Feeling hot or cold	**Other:** □ Cancer Type:____________ □ Fibromyalgia □ Lupus □ Anemia □ Hemophilia	**Liver Conditions:** □ Hepatitis A □ Hepatitis B □ Hepatitis C	**Head, ears, eyes, nose & throat:** □ Headaches □ Headaches, migraine □ Blurred vision □ Eye pain □ Glaucoma □ Ears ringing □ Ear infection □ Sinus problems □ Nose problems □ Teeth grinding □ TMJ/Jaw pain

Men only:
Date of last prostate exam:___________________ □ N/A

Women only:
Are you pregnant right now? □ Yes □ No □ Maybe □ Trying
Number of: Pregnancies:____ Births:____ Miscarriages:____
Age at menopause:______ Hysterectomy: □ Yes □ No If yes, date:________________
Check all that apply: □ Painful periods □ Infertility □ Menopausal symptoms □ Premenstrual problems □ Endometriosis □ Fibroids □ Ovarian cysts

Medications & Operations/Surgeries

Please list any medications and/or supplements that you are currently taking:

Drug/Supplement Reason for taking For how long Frequency Side effects?

____

____

____

____

____

I am taking coumadin/warfarin □ Yes □ No

Please list any previous operations or surgeries that you have had:

Procedure Date Other relevant information

____

____

____

I have a pacemaker □ Yes □ No

Family History & General Health

Please check and circle M: mother, F: father, or B: both for any family history:
□ Cancer (M/F/B) □ Heart Disease (M/F/B) □ Arthritis (M/F/B) □ Stroke (M/F/B) □ Unsure

Do you exercise regularly? □ Yes □ No Type & Frequency:_______________________________________

What are your health and fitness goals? (check all that apply):
□ Overall health/fitness □ Weight loss □ Improved strength
□ Improved cardiovascular activity □ Return to activity □ Increase exercise frequency
□ Increase intensity of exercise □ New exercise program/plan
□ Marathon/triathlon/sporting event □ Other:____________________

How would you rate your overall flexibility on a scale of 0 to 10 (10 being very flexible):_______

Do you regularly consume any of the following (if yes, please check & indicate quantity):
□ Cigarettes ____ packs/day □ Coffee/Tea ____cups/day □ Alcohol ____drinks/week

How would you rate the following areas of your health in the past month:
Stress: □ Great □ Good □ Fair □ Poor Comments:____
Energy: □ Great □ Good □ Fair □ Poor Comments:____
Sleep: □ Great □ Good □ Fair □ Poor Comments:____
Diet: □ Great □ Good □ Fair □ Poor Comments:____
Exercise: □ Great □ Good □ Fair □ Poor Comments:____

How would you rate your current stress levels: □ Extreme □ Very high □ High □ Moderate □ Low

Space below for doctor's use only:

Additional Notes:

Consent to Chiropractic Examination & Treatment

I _________________________________ do hereby give my consent to the performance of chiropractic evaluation and conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of chiropractic adjustments involving movement of the joints and soft tissues. Soft tissue release techniques such as ART® or Graston® as well as physical therapy modalities may be used.
Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Soreness: Like exercise it is common to experience mild muscle soreness after the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are rare.
Fractures/Joint Injury: In isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative discs, or other abnormality is detected, this office will proceed with extra caution.
Worsening of symptoms: Rarely, symptoms may become worse after treatment.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. Nerve or brain damage including stroke is reported to occur at an incidence of 1 in 1 million to 1 in 10 million cervical adjustments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.
To attest to my consent to these procedures, I hereby affix my signature to this authorization for examination and treatment.

Signature Date

Patient Health Information Consent

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Please note that as we do have an open-style treatment room, conversations may be overheard by others during treatment. If you have a specific health issue that you would like to speak with the doctor about privately, please let him/her know. We have a private treatment room available for these instances.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature Date