# CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

**Gray Family Chiropractic, PLLC**
**Dr. Stacy C. Gray, D.C., CACCP**
4908 Professional Court
Raleigh, NC 27609
(919) 850-2440
Fax(919)850-2441
www.GrayFamilyChiropractic.com

**Today's Date (MM/DD/YYYY)**

**Have you consulted a chiropractor before?** ○ No ○ Yes

**Patient Number** (office use only)

**Whom may we thank for referring you?**

**When?**

**If so, whom?**

**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**

**Your First Name**

**Your Middle Name (or Initial)**

**Smoking Status (age 13 and over)** ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

**Address**

**Marital Status** ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

**City** **State/Province** **ZIP/Postal Code**

**Preferred Language**

**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**

CONFIDENTIAL HEALTH INFORMATION

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

**Primary Complaint**
The primary symptom that prompted me to seek care today is: _____

**And are the result of (darken circle):**
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

**Onset** (When did you first notice your current symptoms?) _____

**Prior interventions** (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

**Secondary Complaint**
The secondary symptom that prompted me to seek care today is: _____

**And are the result of (darken circle):**
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

**Onset** (When did you first notice your current symptoms?) _____

**Prior interventions** (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

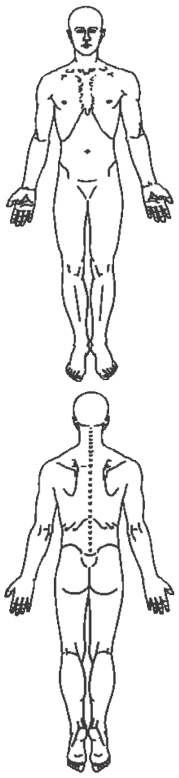
**Additional Complaint**
The additional symptom that prompted me to seek care today is: _____

**And are the result of (darken circle):**
- ◯ An accident or injury ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

**Onset** (When did you first notice your current symptoms?) _____

**Prior interventions** (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

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



**1. What else should Dr. Gray know about your current condition?** _____

**2. How does your current condition interfere with your:**

**Work or career:** _____

**Recreational activities:** _____

**Household responsibilities:** _____

**Personal relationships:** _____

**3. Review of Systems**
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

**a. Musculoskeletal**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Osteoporosis | ◯ | ◯ | Arthritis | ◯ | ◯ | Scoliosis | ◯ | ◯ | Neck pain | ◯ | ◯ | Back problems | ◯ | ◯ | Hip disorders |
| ◯ | ◯ | Knee injuries | ◯ | ◯ | Foot/ankle pain | ◯ | ◯ | Shoulder problems | ◯ | ◯ | Elbow/wrist pain | ◯ | ◯ | TMJ issues | ◯ | ◯ | Poor posture |

NONE ◯ Initials ____

**b. Neurological**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Anxiety | ◯ | ◯ | Depression | ◯ | ◯ | Headache | ◯ | ◯ | Dizziness | ◯ | ◯ | Pins and needles | ◯ | ◯ | Numbness |

NONE ◯ Initials ____

**c. Cardiovascular**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | High blood pressure | ◯ | ◯ | Low blood pressure | ◯ | ◯ | High cholesterol | ◯ | ◯ | Poor circulation | ◯ | ◯ | Angina | ◯ | ◯ | Excessive bruising |

NONE ◯ Initials ____

**d. Respiratory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Asthma | ◯ | ◯ | Apnea | ◯ | ◯ | Emphysema | ◯ | ◯ | Hay fever | ◯ | ◯ | Shortness of breath | ◯ | ◯ | Pneumonia |

NONE ◯ Initials ____

**e. Digestive**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Anorexia/bulimia | ◯ | ◯ | Ulcer | ◯ | ◯ | Food sensitivities | ◯ | ◯ | Heartburn | ◯ | ◯ | Constipation | ◯ | ◯ | Diarrhea |

NONE ◯ Initials ____

**f. Sensory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Blurred vision | ◯ | ◯ | Ringing in ears | ◯ | ◯ | Hearing loss | ◯ | ◯ | Chronic ear infection | ◯ | ◯ | Loss of smell | ◯ | ◯ | Loss of taste |

NONE ◯ Initials ____

**g. Skin**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ◯ | ◯ | Skin cancer | ◯ | ◯ | Psoriasis | ◯ | ◯ | Eczema | ◯ | ◯ | Acne | ◯ | ◯ | Hair loss | ◯ | ◯ | Rash |

NONE ◯ Initials ____

**Patient name** _____

**Patient Number** (office use only) _____

**Doctor's Initials** _____

**Gray Family Chiropractic, PLLC**
**Dr. Stacy C. Gray, D.C., CACCP**

*(Continued from previous page)*

**h. Endocrine**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Thyroid issues | ○ | ○ | Immune disorders | ○ | ○ | Hypoglycemia | ○ | ○ | Frequent infection | ○ | ○ | Swollen glands | ○ | ○ | Low energy | Initials ____ |

**i. Genitourinary**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Kidney stones | ○ | ○ | Infertility | ○ | ○ | Bedwetting | ○ | ○ | Prostate issues | ○ | ○ | Erectile dysfunction | ○ | ○ | PMS symptoms | Initials ____ |

**j. Constitutional**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Fainting | ○ | ○ | Low libido | ○ | ○ | Poor appetite | ○ | ○ | Fatigue | ○ | ○ | Sudden weight gain/loss (circle one) | ○ | ○ | Weakness | Initials ____ |

**Patient name**

**Patient Number**
**(office use only)**

○ All other systems negative

## Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

### 4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

| Had | Have | | Had | Have | |
|---|---|---|---|---|---|
| ○ | ○ | AIDS | ○ | ○ | Tuberculosis |
| ○ | ○ | Alcoholism | ○ | ○ | Typhoid fever |
| ○ | ○ | Allergies | ○ | ○ | Ulcer |
| ○ | ○ | Arteriosclerosis | ○ | ○ | Other: _____ |
| ○ | ○ | Cancer | | | |
| ○ | ○ | Chicken pox | | | |
| ○ | ○ | Diabetes | | | |
| ○ | ○ | Epilepsy | | | |
| ○ | ○ | Glaucoma | | | |
| ○ | ○ | Goiter | | | |
| ○ | ○ | Gout | | | |
| ○ | ○ | Heart disease | | | |
| ○ | ○ | Hepatitis | | | |
| ○ | ○ | HIV Positive | | | |
| ○ | ○ | Malaria | | | |
| ○ | ○ | Measles | | | |
| ○ | ○ | Multiple Sclerosis | | | |
| ○ | ○ | Mumps | | | |
| ○ | ○ | Polio | | | |
| ○ | ○ | Rheumatic fever | | | |
| ○ | ○ | Scarlet fever | | | |
| ○ | ○ | Sexually transmitted disease | | | |
| ○ | ○ | Stroke | | | |

### 7. Allergies

Are you allergic to any medications?

| Yes | No | |
|---|---|---|
| ○ | ○ | If Yes please list: _____ |

### 5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

### 6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

| Past | Currently | |
|---|---|---|
| ○ | ○ | Acupuncture |
| ○ | ○ | Antibiotics |
| ○ | ○ | Birth control pills |
| ○ | ○ | Blood transfusions |
| ○ | ○ | Chemotherapy |
| ○ | ○ | Chiropractic care |
| ○ | ○ | Dialysis |
| ○ | ○ | Herbs |
| ○ | ○ | Homeopathy |
| ○ | ○ | Hormone replacement |
| ○ | ○ | Inhaler |
| ○ | ○ | Massage therapy |
| ○ | ○ | Physical therapy |
| ○ | ○ | Medications |

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

### 8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

*Consultation Notes*

### 9. Family History

Some health issues are hereditary. Tell Dr. Gray about the health of your immediate family members.

FAMILY

| Relative | Age (If living) | State of health | | Illnesses | Age at death | Cause of death | |
|---|---|---|---|---|---|---|---|
| | | Good | Poor | | | Natural | Illness |
| Mother | | ○ | ○ | | | ○ | ○ |
| Father | | ○ | ○ | | | ○ | ○ |
| Sister 1 | | ○ | ○ | | | ○ | ○ |
| Sister 2 | | ○ | ○ | | | ○ | ○ |
| Brother 1 | | ○ | ○ | | | ○ | ○ |
| Brother 2 | | ○ | ○ | | | ○ | ○ |
| _____ | | ○ | ○ | | | ○ | ○ |

**10. Are there any other hereditary health issues that you know about?** _____

### 11. Social History

Tell Dr. Gray about your health habits and stress levels.

SOCIAL

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcohol use | ○ Daily | ○ Weekly | How much? _____ | Prayer or meditation? | ○ Yes | ○ No |
| Coffee use | ○ Daily | ○ Weekly | How much? _____ | Job pressure/stress? | ○ Yes | ○ No |
| Tobacco use | ○ Daily | ○ Weekly | How much? _____ | Financial peace? | ○ Yes | ○ No |
| Exercising | ○ Daily | ○ Weekly | How much? _____ | Vaccinated? | ○ Yes | ○ No |
| Pain relievers | ○ Daily | ○ Weekly | How much? _____ | Mercury fillings? | ○ Yes | ○ No |
| Soft drinks | ○ Daily | ○ Weekly | How much? _____ | Recreational drugs? | ○ Yes | ○ No |
| Water intake | ○ Daily | ○ Weekly | How much? _____ | | | |

Hobbies: _____

**Doctor's Initials**

**Gray Family Chiropractic, PLLC**
**Dr. Stacy C. Gray, D.C., CACCP**

**12. 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 | ○ | ○ | ○ | ○ |
| Rising out of chair | ○ | ○ | ○ | ○ |
| Standing | ○ | ○ | ○ | ○ |
| Walking | ○ | ○ | ○ | ○ |
| Lying down | ○ | ○ | ○ | ○ |
| Bending over | ○ | ○ | ○ | ○ |
| Climbing stairs | ○ | ○ | ○ | ○ |
| Using a computer | ○ | ○ | ○ | ○ |
| Getting in/out of car | ○ | ○ | ○ | ○ |
| Driving a car | ○ | ○ | ○ | ○ |
| Looking over shoulder | ○ | ○ | ○ | ○ |
| Caring for family | ○ | ○ | ○ | ○ |

| | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Grocery shopping | ○ | ○ | ○ | ○ |
| Household chores | ○ | ○ | ○ | ○ |
| Lifting objects | ○ | ○ | ○ | ○ |
| Reaching overhead | ○ | ○ | ○ | ○ |
| Showering or bathing | ○ | ○ | ○ | ○ |
| Dressing myself | ○ | ○ | ○ | ○ |
| Love life | ○ | ○ | ○ | ○ |
| Getting to sleep | ○ | ○ | ○ | ○ |
| Staying asleep | ○ | ○ | ○ | ○ |
| Concentrating | ○ | ○ | ○ | ○ |
| Exercising | ○ | ○ | ○ | ○ |
| Yard work | ○ | ○ | ○ | ○ |

**13. What is the major stressor in your life?** _____

**14. How much sleep do you average per night?** _____ **Hours**

**15. What is the type and approximate age of your mattress and pillow?** _____

**16. What is your preferred sleeping position?** _____

**17. Describe your typical eating habits**: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

**18. What would be the most significant thing that you could do to improve your health?** _____

**19. In addition to the main reason for your visit today, what additional health goals do you have?** _____

**Acknowledgements**
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient (or Guardian's) signature _____ Date (MM/DD/YYYY) _____

*Consultation Notes*

**Patient name** _____

**Patient Number**
**(office use only)** _____

**Doctor's Initials** _____

**Gray Family Chiropractic, PLLC**
**Dr. Stacy C. Gray, D.C., CACCP**

# Back Index

ACN Group, Inc. Form BI-100

*ACN Group, Inc. Use Only rev 3/27/2003*

***Patient Name*** _____ ***Date*** _____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## *Pain Intensity*

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

## *Sleeping*

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

## *Sitting*

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

## *Standing*

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

## *Walking*

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

## *Personal Care*

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

## *Lifting*

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

## *Traveling*

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

## *Social Life*

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

## *Changing degree of pain*

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Back Index Score* _____

# Neck Index

ACN Group, Inc. Form NI-100

*ACN Group, Inc. Use Only rev 3/27/2003*

***Patient Name*** _____ ***Date*** _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## *Pain Intensity*

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

## *Sleeping*

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

## *Reading*

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

## *Concentration*

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

## *Work*

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

## *Personal Care*

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

## *Lifting*

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

## *Driving*

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

## *Recreation*

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

## *Headaches*

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Neck Index Score* _____

# Informed Consent for Chiropractic Care at

# Gray Family Chiropractic, PLLC

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 at 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 are recommended. 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.

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I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

| | |
|---|---|
| _____ | _____ |
| Patient Name (printed) | Relationship to patient |
| _____ | _____ |
| Patient or legal Guardian Signature | Date |
| _____ | _____ |
| Witness Signature (office staff) | Date |
| _____ | _____ |
| Reviewed by Doctor | Date |

# PATIENT BILLING AND ASSIGNMENT FORM

To: Gray Family Chiropractic

In consideration of your undertaking treatment at this office, I agree to the following:
(**Please initial each statement and sign and date at the bottom**)

_____ Due to constant changes in all insurance plans, I agree to be solely responsible for knowing my chiropractic benefits. Our office will do our best to verify benefits for you, however, it is your responsibility to update us when any changes occur in your plan, or to let us know when you have a new insurance plan. I will be responsible for all charges that my insurance company does not pay or cover.

_____ I will be financially responsible for any co-payments, co-insurance, and deductibles for covered services, as well as responsible for services that exceed benefits limits. I will also be financially responsible for all non-covered services as defined by my health plan contract.

_____ For patients with some United Healthcare plans: these plans are administered by the OptumHealth Care Solutions and these plans require us to obtain authorization for any chiropractic treatment. OptumHealth Care Solutions will only authorize acute care, and they will NOT cover wellness or maintenance care. You will be financially responsible for any visits that are not authorized and covered by OptumHealth Care Solutions, regardless of your benefits from United Healthcare. (only initial if you have UHC)

_____ For patients with BCBS except for City of Cary and SAS employees, Cigna, and all Medicare plans will only authorize acute care, and they will NOT cover wellness or maintenance care.

_____ Gray Family Chiropractic is authorized to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process and claim reimbursement of charges incurred at this office.

_____ I authorize the direct payment to Gray Family Chiropractic of any sum I now or hereafter owe you by my attorney or insurance company, to reimburse me for the total charges for services from Gray Family Chiropractic. I am also aware that any amount past due over 60 days will be charged a monthly interest fee of 1 ½ % until final payment is received.

_____ _____
Patient name – Printed Date

_____ _____
Patient Signature Office Representative