GRAHAM CHIROPRACTIC

Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Gender: ○ Female ○ Male

Your Last Name | **Your First Name** | **Middle Initial**

Date of Birth (MM/DD/YYYY)

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

Address

City | **State** | **Zip/Postal Code** | **Spouse's Name & Birth Date**

Home Phone | **Cell Phone** | **Child's Name & Age**

E-Mail Address | **Child's Name & Age**

Emergency Contact | **Phone** | **Child's Name & Age**

Your Occupation | **Your Employer**

How can we help you today?

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 have read and review 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 the 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 ____ **I may request a copy of the Financial Policy at any time.**

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.

Signature | **Date (MM/DD/YYYY)**

If the patient is a minor child, print child's full name: _____

CONFIDENTIAL HEALTH INFORMATION

I hereby request and consent to the performance of procedures, including various modes of physio therapy, chiropractic adjustments, examinations, acupuncture, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Graham Chiropractic and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers named below, including those working at the clinic or office listed below or any office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Graham Chiropractic provider and/or with other office or clinic personal the nature and purpose of the procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the Graham Chiropractic provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is my best interest.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but are not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; steroid injections; bracing; surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____ Date: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Exam - Patient History

_____ _____

Today's Date Patient Name

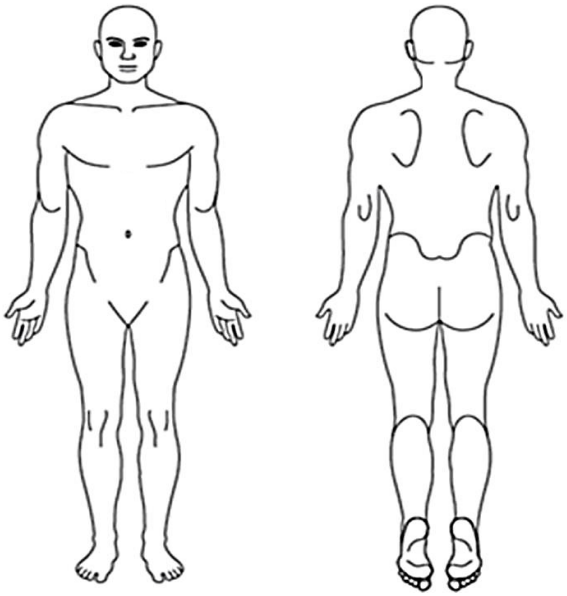
1. **What symptoms prompted you to seek care today?**

_____

2. **When did these symptoms start? How did they start?**

_____

_____



3. **Quality of symptoms** (what does it feel like?)

○ Numbness	○ Heavy
○ Tingling	○ Sharp
○ Tightness	○ Burning
○ Dull	○ Shooting
○ Aching	○ Throbbing
○ Cramps	○ Other _____

4. **Duration & Timing** (how often do you feel it?)
○ Constant ○ Comes and goes

5. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?) _____

6. **Pain Scale: 0 1 2 3 4 5 6 7 8 9 10**

None Mild Mod Severe Worst

7. **Condition improves when:** _____

8. **Prior operations, injuries or treatments:** _____

_____

_____

Allergies: _____ Tobacco use: _____

Medications/Supplements: _____

9. **Review of Systems:**

a. **Musculoskeletal System-** osteoporosis, arthritis, gout, hip disorder, pins/screws, TMJ

b. **Neurological System-** anxiety, depression, headaches, dizziness, epilepsy, stroke

c. **Cardiovascular System-** high BP, low BP, high cholesterol, heart attack, pace maker

d. **Integumentary System-** skin cancer, psoriasis, eczema, acne, hair loss, rashes

e. **Genitourinary System-** kidney stones, infertility, bedwetting, prostate issues, PMS symptoms

f. **Constitutional System-** fainting, low libido, poor appetite, fatigue, sudden weight loss/gain

g. **Lymphatic System-** swelling or pain in lymph nodes of neck, axillae, groin & other areas

h. **Respiratory System-** asthma, emphysema, tuberculosis

e. **Endocrine System-** diabetes, steroid treatments, thyroid problems

f. **Gastrointestinal System-** colitis, colon cancer, reflux, pancreatitis

10. **FRI Scale:**

Frequency (% of day)	0 No Pain	1 25%	2 50%	3 75%	4 100%
Pain Intensity	0 No Pain	1 Mild	2 Moderate	3 Severe	4 Worst Possible
Sleeping	0 Perfect	1 Mildly Disturbed	2 Moderately Disturbed	3 Greatly Disturbed	4 Totally Disturbed
Recreation	0 Can do all Activities	1 Can do most Activities	2 Can do some Activities	3 Can do few Activities	4 None
Self-Care	0 No Pain No Restrictions	1 Mild Pain	2 Moderate Slow Moving	3 Moderate Some ast.	4 Severe 100% ast.
Lifting (Weight)	0 No Pain Heavy	1 Increased Heavy	2 Increased Moderate	3 Increased Light	4 Increased Any
Travel	0 No Pain Long Trips	1 Mild Pain Long Trips	2 Moderate Long Trips	3 Moderate Short Trips	4 Severe Short Trips
Walking (Distance)	0 Unlimited	1 1 Mile	2 ½ Mile	3 ¼ Mile	4 Any
Work	0 Usual duties + extra work	1 Usual Duties no extra	2 Can do 50% of usual	3 Can do 25% of usual	4 Can't work
Standing (Hours)	0 No Pain Several	1 Increased Several	2 Increased 1 Hour	3 Increased ½ Hour	4 Any Standing