CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

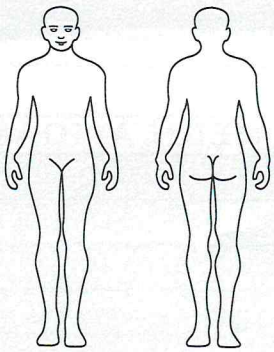
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients *JMPT* 2002; 25 (3): 141-148.

Auto-Accident History : Accident History | Auto-Accident History

Date of Accident : Time of Accident AM [HH:MM]

City : State : Select State

What type of vehicle were you in? : Make : Year :

Other Vehicle Make: Year :

Where were you in the vehicle? : ☐ Passenger ○ Front ○ Back ○ Left-Side ○ Right-Side

What was the speed of your vehicle?

Was it ? ○ Daylight ○ Night ○ Dusk ○ Dawn

What was the visibility? ○ Excellent ○ Reduced

Were Brakes applied? ○ Yes ○ No

Type of Road? ○ 2-Lane ○ 3-Lane ○ 4-Lane ○ Gravel ○ Tar

What were the Road conditions? ○ Slippery ○ Wet ○ Dry ○ Damp ○ Muddy ○ Sandy ○ Icy

Did it happen at? ○ Traffic Light ○ Stop Sign ○ Intersection ○ Highway

Was your Car Hit? ○ Front ○ Back ○ Left-Side ○ Right-Side

If you Struck another car, did you strike it at? ○ Front ○ Back ○ Left-Side ○ Right-Side

Damage to your Car?

Damage to the other Car?

Air Bags Deployed? ○ Yes ○ No

Was Police Report Filed? ○ Yes ○ No

Did you hit any part of your body during the collision, for example: head on dash, chest on steering wheel? ○ Yes ○ No

(500 Character Limit)

If yes, which part and how :

What was the position of your head and neck prior to impact : ○ Up ○ Down ○ Level ○ Straight ○ Turned Left ○ Turned Right

Were you reclined? ○ Yes ○ No

Seat Belts On? ○ Yes ○ No Shoulder Harness On : ○ Yes ○ No

Position of Headrest? ○ Adjusted Low ○ Adjusted High ○ Improperly Adjusted ○ Normal

Were you conscious after the accident? ○ Yes ○ No

Did you receive emergency care at the scene? ○ Yes ○ No

Were you hospitalized? ○ Yes ○ No If yes, for how long? :

Describe any additional details about the Accident :

Have you retained an Attorney? ○ Yes ○ No

If yes, Name and Address of Attorney:

Accident and Injury Questionaire

This information will be strictly confidential. Your answers will help us determine if Chiropractic care will benefit you. Please print and be as accurate and complete as possible.

Date of Accident or Injury: _____
Were you a pedestrian (on foot) when the accident happened? ☐ Yes ☐ No
Were you the: ( ) driver ( ) passenger ( ) front seat ( )back seat If you were not the driver, please list the name of the driver: _____ Who owns the car you were injured in?_____ Year and make of vehicle: _____
Number of people in your vehicle_____ Were you wearing seatbelts?_____
What direction were you headed? ( ) north ( ) east ( ) south ( ) west
On (name of street) _____
What direction was other vehicle headed? ( )north ( ) east ( ) south ( ) west
On (name of street) _____
Were you struck from: ( ) behind ( )front ( ) left side ( ) right side
Approximate speed of your car _____mph Other car_____mph
Were you knocked unconscious? ( ) yes ( )no If yes, for how long?_____
Have you seen any other physician for this accident? ( ) yes ( ) no If yes, please describe where and treatment that you received: (x-rays, physical therapy, or any medications) _____
_____
Did your body strike anything in the car? ( ) yes ( ) no Please describe, if yes, _____
In your own words, please describe the accident: _____
_____
_____

Were you taken to the hospital after the accident? ( ) yes ( ) no _____

Did you have any physical complaints before the accident? ( )yes ( ) no If yes, please describe in detail:_____
_____
_____

Please describe how you felt:
DURING the accident: _____
IMMEDIATELY after the accident:_____
LATER THAT DAY: _____
THE NEXT DAY: _____

What are your present complaints and symptoms?_____
_____
_____

Do you have any congenital (from birth) factors, which relate to your complaints? ( )yes ( ) no If yes, please describe: _____

Do you have any previous illnesses, which relate to this case? ( ) yes ( ) no If yes, please describe:
_____

Have you ever been involved in an accident before? ( ) yes ( ) no If yes, please describe date and type of accident, as well an injuries received: _____

_____

_____

Type of treatment received:_____

_____

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

[ ] Headache	[ ] Irritability	[ ] Numbness in toes	[ ] Face Flushed	[ ] Feet cold
[ ] Neck pain	[ ] Chest pain	[ ] Shortness in breath	[ ] Buzzing in ears	[ ] Hands cold
[ ] Neck stiff	[ ] Dizziness	[ ] Fatigue	[ ] Loss of Balance	[ ] Stomach upset
[ ] Sleeping problems	[ ] Head seems too heavy	[ ] Depression	[ ] Fainting	[ ] Constipation
[ ] Back pain	[ ] Pins & needles in arms	[ ] Lights bothers eyes	[ ] Loss of smell	[ ] Cold Sweats
[ ] Nervousness	[ ] Pins & needles in legs	[ ] Loss of Memory	[ ] Loss of taste	[ ] Fever
[ ] Tension	[ ] Numbness in fingers	[ ] Ears Ring	[ ] Diarrhea	

Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this Question:

a. Last day worked:_____

b. Present salary: _____

c. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving:_____

Is there any activity that you have noticed since this accident that you have difficulty in doing or cannot do? ( ) Yes ( ) No If yes, please describe, in detail:_____

_____

I understand and agree that health and accident policies are an arrangement between the carrier and myself. Furthermore, I understand that the Doctor will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and assign benefits for such payment to my doctor. I clearly understand that if I suspend my care, any fees for professional services rendered me will be immediately due and payable. I further understand that liability policies will pay me directly for the services rendered me and I will pay to Dr. Grau, immediately upon settlement, in full the amount owed for my care.

_____ _____

Patient's signature (Parent's if minor) Date

INFORMATION ABOUT THE PARTIES TO THE ACCIDENT:

Did a police write up a police report on the accident? ( )yes ( )no
Do you have a copy of the police report? ( )yes ( )no If yes, please provide our office with a copy
Was a ticket or citation issued by a police officer as a result of the accident? ( )yes ( )no
Who received the citation?_____
Did the accidnet involve a hit-and-run driver? ( )yes ( )no
Is the car that was involved with the accident properly registered? ( )yes ( )no
Were you in your own vehicle or someone else's at the time of the accident? Check one
( )in my own vehicle ( )the other person's vehicle ( )my parent's ( )a friend ( )other
If you were in someone else's vehicle, answer the following:
Name of the owner:_____
Address of the owner:_____

Was there any property damage to either of the vehicles as a result of the accidnet?
( )both vehicles ( )the other person's vehicle ( )the vehicle I was in ( )neither vehicle was damaged

Your Auto Insurance Company(at the time of the accident:_____Phone or City:____
Agent:_____Phone or city:_____
Have you been contacted by an adjuster from the other party's insurance company regarding this claim? ( )yes ( )no Name of adjuster:_____Company_____
Phone:_____
Check all that apply:( )I have settled my peronal injury claim with this company
( )I have settled the property damage claim ( ) I have signed an agreement which will pay my medical expenses for a period of time
(explain)_____
( )I have not signed any agreement, nor settled any portion of my claim

Are you currently represented by an attorney? ( )yes ( )no If no, do you wish to retain an attorney? ( )yes ( )no

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have had the following unusual risks of my case explained to me.**
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date

Health Insurance Portability and Accountability Act (HIPAA) Consent

General

This office transmits patient protected health information electronically. In seeking medical advice or receiving medical care in this practice Protected health Information (PHI) will be generated on you. This information includes your medical information (past, present, and future) and personal information such as our name, address, and social security number. This information will be used for the Treatment of your medical condition(s), obtaining payment from your insurance company and for Healthcare Operation (TPO) within this practice.

Privacy Practice Notice

For a more complete description of how your Protected Health Information may be used and disclosed, you may review this practice's "Notice of Privacy Practices". A copy of the Privacy Practices for Protected Health Information is available at the reception desk and a copy in the waiting room. You may keep the copy for your records.

Individual Rights:

You have the right to restrict the uses and disclosures of your Protected health Information (PHI) for the purpose of your treatment, payment for you services and the healthcare operations of this practice. This practice is not required to agree to requested restrictions but is bound by any restrictions to which it agrees.

You have the right to restrict the uses and disclosures of your Protected Health Information (PHI) for the purpose of your treatment, payment of your services and the healthcare operations of this practice. This practice is not required to agree to requested restrictions but is bound by any restrictions to which it agrees.

You have the right to revoke this consent in writing, except to the extent that our practice has taken action on reliance of this consent.

This practice has the right to refuse to treat you if you refuse to sign this consent or if you, any anytime, revoke this consent.

Your signature below acknowledges:

- You have read and understand this consent
- You have agreed to have your protected health information used by this practice for the purpose of your treat, and for this practice's healthcare operations.
- Prior to signing this consent, you were given the opportunity to review this practice's "Notice of Privacy Practices"
- You are aware that you may now or at any time request restrictions to the use and disclosure of your protected health information
- This consent may be terminated at any time, with written request, except to the extent this practice has taken action in reliance of the consent.

_____

Signature of Patient or Patient's Representative

_____ _____

Printed Name and Authority of Representative Date

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office will accept your insurance on assignment. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office DOES NOT guarantee your insurance policy or payments.

2. Your insurance will be filed as a courtesy to you. We file insurance claims on a daily basis.

3. You are required to sign an "Assignment of Benefits" form and any other forms required by your insurance company on your first visit.

4. If your insurance company requires their own claim form(s), you are required to bring in the completed form(s) by your second visit and then as needed.

5. You will be responsible for your deductible and co-payment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.

6. Your insurance should pay within 60 days from the date in which it was filed.

7. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to pay.

8. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

9. Any overpayments made by your insurance company which credits your account will be refunded to them. However, any overpayments or errors in amounts paid which does not credit your account will be your responsibility.

10. If you discontinue care without the doctor's authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay, after your account has been paid, refunds will be sent to you.)

I have read and understand the policy regarding insurance assignments. I realize that I am responsible for all charges incurred by me at this office.

_____ _____

Signature Date

_____ _____

Witness Date