Grain Valley Chiropractic, LLC

Date: _____ Patient #_____ **Doctor: _____**

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

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

REMINDERS: Text or Email? Age: _____ Birth Date: _____ Race: _____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone: _____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Emergency Contact:_____ Relationship:_____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? _____

Please check all insurance coverage that may be applicable in this case**:**

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic 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 _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: _____

Date symptoms appeared or accident happened:_____

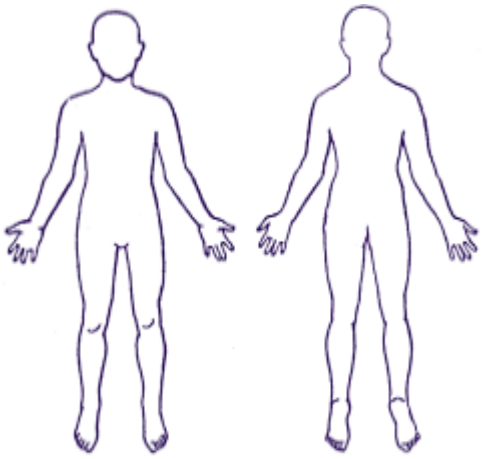
Is this due to: Auto___ Work____ Other_____

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

_____

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

Using the letters below, mark on the diagram where you feel pain.



FRONT BACK

NUMBNESS	N
DULL ACHE	A
BURNING	B
SHARP/STABBING	S
PINS/NEEDLES	T

Please circle the degree of pain: LOW 0 1 2 3 4 5 6 7 8 9 10 HIGH

How are your symptoms changing? Getting better Not changing Getting worse

How often do you experience your symptoms?

Constant Frequent Occasionally Intermittently

Does anything improve your pain? _____

Does anything make the pain worse? _____

When did your symptoms begin? _____

How did your symptoms begin? _____

PATIENT NAME _____ DATE _____

Please circle any symptoms you have had or are having now.

MUSCLE AND JOINTS	NEUROLOGICAL	CARDIOVASCULAR	ENDOCRINE
Neck Pain	Anxiety/Depression	High blood pressure	Diabetes
Back Pain	Epilepsy/Seizures	High cholesterol	Thyroid Problems
Poor Posture	Headaches	Blood clots or Stroke	Other
Broken bones	Migraines	Heart Trouble	
Implants, pins, or screws	Dizziness	Heart attack	
Arthritis General	Numbness	Heart Surgery	
OA	Pins & needles	Aortic Aneurysm	**GENERAL**
RA	Other	Other	Are you Pregnant?
Psoriatic			Diagnosed with cancer?
Other			

GASTROINTESTINAL	DERMATOLOGICAL	RESPIRATORY	GENITOURINARY
Nausea	Bruising easy	Sleep Apnea	Frequent Urination
Abdominal Pain	Eczema, Rash or Dermatitis	Asthma	Prostate Problems
Ulcer	Psoriasis	Persistent cough	Kidney Stones
Colon Problems	Skin cancer	Tuberculosis	Other
Liver/Gallbladder Trouble	Other	Other	
Other			

EXERCISE	**WORK ACTIVITY**	**INJURIES**	**SURGERIES**
How often do you exercise and what type(s) do you perform?	What physical activities are prominent at your job?	Please list any injuries and when they occurred. (including broken bones)	Please list any surgeries and when they occurred.

HABITS	**ALLERGIES**	**MEDICATIONS**	**VITALS (OFFICE USE ONLY)**	
SMOKING: ___ PACKS A DAY ALCOHOL: ___ DRINKS A WEEK CAFFEINE: ___ CUPS A DAY OTHER: _____	Please list any allergies you suffer from.	Please list any medicine you take regularly.	HEIGHT	
			WEIGHT	
			BP	
			PULSE	
			TEMP	

PATIENT NAME _____ DATE _____

FAMILY HISTORY										
Please review the below-listed diseases and conditions and indicated those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.										
CONDITION	**FATHER** **AGE ( )**	**MOTHER** **AGE ( )**	**SPOUSE** **AGE ( )**	**BROTHER** **AGE ( )** **AGE ( )**		**SISTER** **AGE ( )** **AGE ( )**		**CHILDREN** **AGE ( )** **AGE ( )**	
Arthritis									
Asthma-Hay fever									
Back Trouble									
Bursitis									
Cancer									
COPD									
Diabetes									
Disc Problems									
Epilepsy									
Headache/Migraine									
Heart Trouble									
High Blood Pressure									
Neuropathy									
Sciatica									
Scoliosis									
Other									

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

Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date: _____

PATIENT NAME _____ DATE _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and if necessary, diagnostic x-rays on me by the chiropractic physician and/or anyone working in this office or authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Grain Valley Chiropractic, LLC, the physician of/other licensed physicians of Grain Valley Chiropractic, LLC who may treat me now or in the future at this office. I have had an opportunity to discuss with physician and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and I am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risk to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the procedure which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s), for which I seek treatment at this facility.

_____ _____

Print Name of Patient **Print Name of responsible party**

_____ _____

Signature of patient or responsible party **Date**

MISSED APPOINTMENT POLICY

Thank you for choosing Grain Valley Chiropractic, LLC as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Please read the missed appointment policy ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

MISSED APPOINTMENT. Our policy is to charge **$25.00** after one missed appointment not cancelled by end of our workday. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment.**

I have read and understood the MISSED APPOINTMENT policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**