File #:_____

GRAETTINGER
chiropractic clinic

Welcome To Our Office!

Today's Date ____/____/____

Name_____ **Preferred Name** _____
First Middle Initial Last

Date of Birth____/____/_____ **Gender** ❑ Male ❑ Female **Social Security #**_____

Address_____**City/State**_____**Zip**_____

Mobile Phone_____-_____-_____ **Home Phone**_____-_____-_____ **Email**_____

If needed, I may be contacted for appointments, treatment, and billing: **via Email:** ❑ Yes ❑ No **via Text:** ❑ Yes ❑ No

Marital Status ❑ Single ❑ Married ❑ Separated ❑ Widowed **Spouse's Name**_____

Employment Status ❑ Employed ❑ Unemployed ❑ Student ❑ Retired ❑ Stay-at-home

Occupation_____ **Employer**_____

Emergency Contact_____ **Phone #**_____-_____-_____ **Relationship**_____

Previous chiropractic care? ❑ Yes ❑ No **Chiropractor's Name**_____

Is today's visit due to a work-related injury or auto accident? ❑ Yes ❑ No *(If yes, please see receptionist for additional paperwork)*

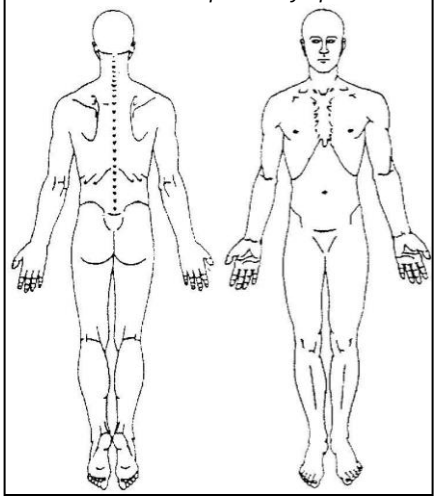
Reason For This Visit

Primary Complaint_____

Secondary Complaint_____

What level of intensity would you rate your pain?
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Mark location of pain or symptoms:



Please select all that apply:

❑ Achy	❑ Burning	❑ Cramping	❑ Deep	❑ Dull
❑ Numbness	❑ Radiating	❑ Sharp	❑ Shooting	❑ Soreness
❑ Stabbing	❑ Stiff	❑ Throbbing	❑ Tightness	❑ Tingling

What is the frequency of your symptoms?
❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

When did the symptoms start?_____

Was the onset… ❑ Gradual ❑ Sudden

How did you injure yourself?_____

Have you ever experienced this in the past? ❑ Yes ❑ No

What home remedies have you tried? ❑ None ❑ Ice ❑ Heat ❑ Stretching ❑ Massage

Have you been to another doctor or chiropractor for this problem? ❑ Yes ❑ No

Does this affect any of the following tasks?

❑ Personal Care	❑ Carrying Objects	❑ Reaching	❑ Walking	❑ Household Chores
❑ Getting In/Out of Bed	❑ Getting Up From Chair	❑ Standing	❑ Driving	❑ Playing Sports
❑ Going to Bathroom	❑ Kneeling	❑ Stair Stepping	❑ Golfing	❑ Sleeping
❑ Putting on Clothes	❑ Leaning Back	❑ Sitting	❑ Exercising	❑ Yard Work
❑ Bending Over	❑ Lifting Objects	❑ Twisting		

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Health Information

What *non-prescription* drugs are you taking? ❑ None ❑ Tylenol ❑ Advil ❑ Ibuprofen ❑ Aspirin ❑ _____

Please list any prescription medications:_____

_____

Are you allergic to any medications? ❑ Yes ❑ No *If yes, please list:* _____

What vitamins/supplements are you taking? ❑ None ❑ Multi-vitamin ❑ Fish Oil ❑ Probiotic ❑ Other_____

Do you smoke? ❑ Yes – Everyday Smoker ❑ Yes - Occasional smoker ❑ Former smoker ❑ Never been a smoker

Do you consume alcohol? ❑ Yes ❑ No # Drinks per week_____

Do you consume caffeine? ❑ Coffee ❑ Soda ❑ Tea ❑ Energy Drinks # Drinks per day_____

Do you exercise? ❑ No ❑ Infrequent ❑ Occasional ❑ Regular ❑ Avoid due to pain

Women Only: Are you pregnant? ❑ Yes ❑ No ❑ Maybe **Number of Weeks**____ **Due Date**____/____/____

Past Health History

Have you ever… *(please briefly describe - what & when)*

Yes	No	
❑	❑	Been in a car accident or had any significant falls/injuries?_____
❑	❑	Been treated for a spine problem/nerve disorder?_____
❑	❑	Fractured/broken a bone?_____
❑	❑	Had surgery?_____
❑	❑	Been hospitalized for other than surgery?_____

Please mark any you currently have or have had previously:

❑ AIDS	❑ Depression	❑ Kidney Stone	❑ Sciatica
❑ Alcoholism	❑ Diabetes	❑ Loss of Memory	❑ Scoliosis
❑ Allergies	❑ Digestions Problems	❑ Loss of Balance	❑ Shortness of Breath
❑ Anemia	❑ Dizziness	❑ Loss of Smell	❑ Sinus Infection
❑ Arteriosclerosis	❑ Excessive Menstruation	❑ Loss of Taste	❑ Sleep Problems/Insomnia
❑ Arthritis	❑ Eye Pain/Difficulties	❑ Migraine Headache	❑ Spinal Curvatures
❑ Asthma	❑ Fatigue	❑ Muscle Cramps	❑ Stroke
❑ Back Pain	❑ Frequent Urination	❑ Neck Pain or Stiffness	❑ Swelling in Ankles
❑ Breast Lump	❑ Headache	❑ Nervousness	❑ Swollen Joints
❑ Bronchitis	❑ Hemorrhoids	❑ Nosebleeds	❑ Thyroid Condition
❑ Bruise Easily	❑ High Blood Pressure	❑ Pacemaker	❑ Tuberculosis
❑ Cancer	❑ Hot Flashes	❑ Polio	❑ Ulcers
❑ Chest Pain/Conditions	❑ Irregular Heart Beat	❑ Poor Posture	❑ Varicose Veins
❑ Cold Extremities	❑ Irregular Cycle	❑ Prostate Issues	❑ _____
❑ Constipation	❑ Kidney Infection	❑ Ringing in Ears	❑ _____

Family History

Father's Side: ❑ Heart Disease ❑ Cancer ❑ Stroke ❑ Arthritis ❑ Diabetes ❑ High Blood Pressure ❑ Other_____

Mother's Side: ❑ Heart Disease ❑ Cancer ❑ Stroke ❑ Arthritis ❑ Diabetes ❑ High Blood Pressure ❑ Other_____

The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

_____
Patient's Signature

GRAETTINGER
chiropractic clinic

Notice of Privacy Practices

Our practice is dedicated to maintain the privacy of your health information according to the guidelines set forth by federal and state law. These laws also require us to provide you with notice of privacy practices, and to inform you of your rights and our obligations concerning your health information. The undersigned hereby acknowledges that I have received, reviewed, and understand and agree to the Notice of Privacy Practices of the Graettinger Chiropractic Clinic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health information created, received or maintained by the Graettinger Chiropractic Clinic.

Initial

Patient's Rights and Responsibilities

Health care involves a partnership between patients, families, and health care providers, each of whom have certain rights and responsibilities. When you are well-informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. This clinic encourages respect for the personal preferences and values of each individual. The undersigned hereby acknowledges that I have received, reviewed, and understand my rights and responsibilities.

Initial

Statement of Informed Consent

Chiropractic adjustments are performed in our office by skilled doctors of chiropractic who have successfully completed advanced educational requirements, national board examinations, and state board examinations. As with any healthcare procedure, there are some inherent risks that exist. Whenever possible this risk is minimized to its lowest level. Our doctors and staff make every effort possible to provide the safest chiropractic care available. The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor.

Initial

Financial Policy

Payment is expected at the time of service. Your insurance company can and will be billed, determined by your preference and our current status as in-network or out-of-network with that company. We cannot guarantee your coverage, even if our office attempts to confirm your benefits and eligibility. Final approval of coverage is based on the explanation of benefits after the claim has been filed. Any balance remaining after insurance benefits are obtained is the responsibility of the patient. If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of receiving a billing statement. We are happy to address questions regarding your account at any time.

Initial

Assignment of Benefits

Assignment of benefits is simply authorizing the Graettinger Chiropractic Clinic to file charges directly to your insurance company, saving you time and effort of filing claims yourself. The undersigned hereby authorizes the Graettinger Chiropractic Clinic to submit my insurance claims to my insurance company. By having my signature on file, I need not sign each claim submitted by their office. I understand that I may withdraw my signature at any time. I also understand that I am ultimately responsible for all charges for which my insurance does not pay.

Initial

Consent to Communication

I understand and consent to have Graettinger Chiropractic Clinic communicate with me as described on Page 1. This may include communications via standard SMS text messaging, email, and other electronic communications regarding various aspects of my medical condition and treatment, which may include, but not limited to, appointments, treatment, billing, payment, referrals, and general health care operations. I further understand that, because of these methods, there is a risk that standard SMS text messaging, email, or other electronic communications regarding my medical condition and treatment including my personal health information might be intercepted or read by a third party. I understand that it is my responsibility to make sure that only authorized people are allowed to access my email, phone messages, and digital devices.

Initial

_____ ____/____/____

Patient Signature Date