CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

GRACE CHIROPRACTIC
SCIENCE - ART - PHILOSOPHY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Mobile**: _____ **Work**: _____

Email: _____ **Gender**: M / F **Marital Status**: Married / Single / Other

Date of Birth:_____ **Occupation:** _____ **Employer:**_____

Spouse/Significant Other: _____ **Children and Ages:**_____

Are you: Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

Referred by *(name)*: _____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other:**_____

-CMS requires providers to report both race and ethnicity-

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**:_____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Preferred Contact Number**:_____

Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____**Doctor's Phone**: _____

FINANCIAL INFORMATION -- ***Please allow us to photocopy your insurance card.***

Self Pay (Cash) **Insurance** **Personal Injury/Auto** **Other (please explain)** _____

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE**:_____

Policy Holder: _____ **Policy Holder**:_____

Relation to Insured: Self / Spouse / Parent / Child / Other **Relation to Insured**: Self / Spouse / Parent / Child / Other

Patient Name: _____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Major Complaint: _____

When Did This Episode Start (date):_____ **What Event Caused It:** _____

If this is NOT the first time, how long has this been a recurring problem? _____

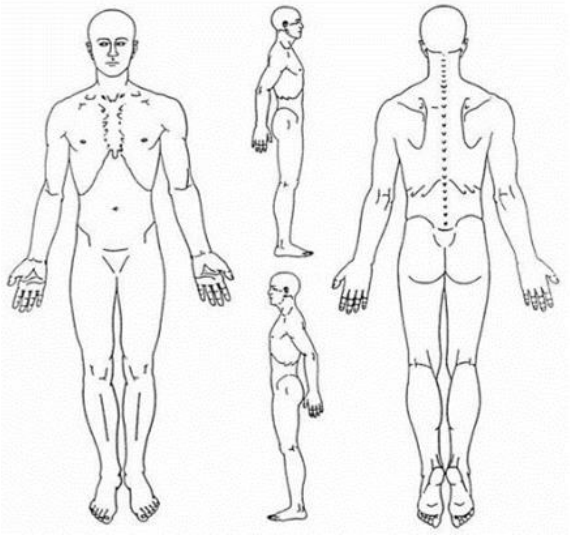
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

The Complaint is: Constant / Comes and Goes

Is The Complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins and Needles Other:_____

Does It Radiate/Shoot To Any Areas Of Your Body? No / Yes **If YES, where:**_____

DRAW AREAS OF COMPLAINTS:



What Makes It Better? Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

What Makes It Worse? Sit / Stand / Walk / Lying / Sleep / Movement

Who Else Have You Seen For This? No One / DC / MD / PT / Massage / ER / Other:_____

- Where: _____

Diagnostic Tests: None / X-rays / MRI / CT / Other:_____ **When and Where:**_____

Any Other Complaints:_____

Patient Name: _____

Does anyone in your IMMEDIATE family have a history of (circle condition): ☐ **NONE**

Heart Disease If yes, who _____ **Stroke** If yes, who _____

Cancer If yes, who _____ Type_____ **Other Relevant Family History**:_____

PAST HEALTH HISTORY: (List even if it was 20 years ago…)

Injuries, Traumas or Hospitalizations: ☐ **NONE** _____

Surgeries – Date, Type and Reason: ☐ **NONE** _____

Current Medications: ***Did you bring a list? Can we make a copy?*** ☐ **NONE** _____

Allergies to Medications: *(List and reactions)* ☐ **NONE**

_____

Vitamins & Supplements: *(List all and frequency)* ☐ **NONE**

_____

Are you ***CURRENTLY*** experiencing any of these symptoms? (Check all that apply)

General:
- ❑ Recent Intentional Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Broken Bones
- ❑ Muscle Spasms/Cramps
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Have you ever had a head injury?
- ❑ Had an auto accident? Year:_____
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Tobacco Use
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear Contacts/Glasses
- ❑ Blurred or Double Vision
- ❑ Eye Disease or Injury
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Cold Extremities
- ❑ Heat or Cold Intolerance
- ❑ Immune System Disorder
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Non-healing Sores
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ *None in this Category*

Genitourinary:
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Urinary Leakage or Bed Wetting
- ❑ Blood in Urine
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date: _____
- ❑ No-Last Menstrual Period: _____
- ❑ Painful or Irregular Periods
- ❑ Urine Leakage with Coughing or Sneezing
- ❑ Urine Leakage with Laughing or Lifting
- ❑ *None in this Category*

Pregnancies with Outcome & Date

_____

_____

Other Conditions not listed:_____

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

Doctor Signature _____ Date _____

OFFICE POLICIES & CONSENT TO CARE

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

1. HIPAA. We will never share your records or information with a third party without your consent. A copy of our privacy policies is in the reception area. We can provide you with a copy upon request.
2. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility; please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral, it is your responsibility to provide us with a referral, dated on or before the date of your first visit, from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
3. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients may be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
4. PROOF OF INSURANCE. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company (or other payor) reimburses for your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
6. COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your claim is not paid within 90 days, the balance will automatically be billed to you.
7. MISSED APPOINTMENT. Our policy is to charge $25.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you.
8. INFORMED CONSENT: I understand and am informed that, as with the practice of medicine, chiropractic carries some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

I have read and understood the office policies, agree to abide by its guidelines, and consent to care for my present conditions(s) and for any future condition(s) for which I seek treatment.

_____ _____

Signature of patient or responsible party **Date**

Patient Name _____