Personal History

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_ Single - Married/Partnered – Separated – Widowed

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to the office by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and phone number of person to contact in case of emergency:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_

Check Type of Insurance Coverage for this Condition:

[ ] Health Insurance [ ] Medicare [ ] Medicaid [ ] Personal Injury

[ ] Workers Comp [ ] Out of Pocket (Cash/Credit) [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason For Consulting This Office:

[ ] I have no problem. I need to maintain my good health with regular Chiropractic treatments.

[ ] I have a problem now, and I need Chiropractic to help me reach my maximum health potential.

[ ] I have a problem now that I need help with. I want to learn how to prevent it in the future.

[ ] I have a problem, and I need help only with this specific problem.

Operations (Please put date and side if applicable):

[ ] Appendectomy: \_\_\_\_\_\_\_\_\_ [ ] Gallbladder: \_\_\_\_\_\_\_\_\_ [ ] Hernia: \_\_\_\_\_\_\_\_\_\_

[ ] Female Organs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Spinal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accidents, Falls, Surgeries (Date and Describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Broken Bones and Dislocations (Date and Location): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CONSENT FOR CHIROPRACTIC CARE:**

I hereby request and consent to chiropractic treatment including physical examination, diagnostic x-rays, manipulations, meridian therapy (acupuncture) and various physical therapy by the doctors and staff of Grand Chiropractic. I shall have the opportunity to discuss the nature, the purpose, and the cost of procedures before they are administered. I understand that results can never be guaranteed. I understand that in the practice of chiropractic, as in the practice of medicine, there are some risks which include sprains, disc injuries, dislocations, strokes, and fractures. I do not expect my doctor to be able to anticipate or explain all risks or complications. I wish to rely on the doctor to use judgment during my course of treatment which he/she believes is in my best interest. I have read or have had read to me this consent and may take the opportunity to ask questions whenever I choose. It is my intention that this consent apply to treatment at any time in the future when I decide to take treatment at Grand Chiropractic.

Patient’s or Guardian’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO TREATMENT OF A MINOR** (17 years old or less):

I authorize the doctors and staff at Grand Chiropractic to administer chiropractic treatment as deemed necessary to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ my\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (relationship).

##### **Please note:** The parent or guardian must accompany the minor for the first visit.

**Insurance Authorization, Release and HIPAA Notification:**

###### Name of primary Insurance Company:

Secondary Insurance Company (if any):

I authorize payment of insurance benefits directly to the chiropractor or the office. I authorize the doctor to release all information to communicate with insurance personnel and other healthcare providers in order to secure the payment of benefits and/or the coordination of care. I understand that I am ultimately responsible for all costs of chiropractic treatment, regardless of insurance coverage. **I hereby promise to assist collections at this office by completing, signing, and mailing insurance forms when necessary.**

###### In so much as I have agreed to allow the use of my patient health information for the purpose of insurance payment and coordination of care, I am still entitled to privacy. I understand my rights to privacy are detailed in the “HIPPA NOTICE” which describes the policy and procedures of this office. This manual is available for my review at the receptionist desk. **(If you want us to discuss your condition with a family member or friend, we need your permission to do so.)**

###### Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Medications (Please Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Allergic to Anything? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Please Circle Any That Applies or Previously Had:

###### Auto Immune Disease Heart Attack Polio

###### Addiction (Alcohol/Drug) Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pregnancy

###### Anxiety Hepatitis A/B/C Recent Fractures

###### Asthma Implants \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Seizures

###### Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Health Dx \_\_\_\_\_\_\_\_\_\_\_\_ Skin Issues or Rashes

###### Depression Osteoarthritis Spinal Injection

###### Diabetes Osteoporosis Stroke

###### Dizziness/Vertigo Pacemaker Tuberculosis

###### Epilepsy Pleurisy Rheumatoid Arthritis

###### High Blood Pressure Pneumonia

###### Metal plates or Pins: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Other Conditions Not Listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Circle any that Apply:

###### Upper Spine: Middle Spine: Lower Spine:

###### Headaches/Migraines Abdominal Pain Blood in Urine

###### Eye/Vision Troubles Constipation Colon Issues

###### Eye Glasses or Contacts Excessive Diarrhea Incontinence

###### Ear Infections (Chronic) Digestive Issues History of Kidney Stone

###### Difficulty Swallowing Gallbladder Issues Menstrual Issues

###### Sinus Troubles Gastric Reflux Ovarian Cysts

###### Hearing Problems Nausea Painful Urination

###### Tinnitus (Ringing in Ear) Ulcers Sexual Dysfunction

###### Memory Issues Vomiting Testicular Pain

###### Loss of Taste or Smell Urinary Tract Infections

###### Sore Throat Urinary Issues

###### TMJ (Jaw) Issues

###### Hot Flashes

######  Irregular Circle

######  Fertility Issues

###### Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_