GRAY CLINIC OF CHIROPRACTIC, Ltd.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you.We look forward to working with you as you regain your health.

1 PATIENT INFORMATION [Please print]

Patient Name				The Name that you would like to be addressed as			
Home Address				City		St	Zip
E-Mail Address				Birthday		Age	
Home Phone #		Cell Phone #			Soc Sec #		
Occupation		Employer			Work Phone #		
Marital Status	M S W D	Spouse Name			Children Names		
How did you find out about this office					Name of your MD		
Previous DC				Date of your last Chiropractic Adjustment			
Emergency Contact		Relationship			Contact Phone #		

2 INSURANCE INFORMATION

Insurance Carrier		Insured's Name		Insured's SocSec#		Insured's Birthdate	

AUTHORIZATION AND RELEASE: I, authorize payment of my insurance benefits directly to the GRAY CLINIC OF CHIROPRACTIC, Ltd. I also authorize the GRAY CLINIC to release all information and complete all forms necessary to communicate with physicians and other healthcare providers and payors necessary to secure the payment of benefits. I understand that my insurance is an agreement between myself and my insurance company, not between the GRAY CLINIC and my insurance company and I understand that I am ultimately responsible for all costs incurred at the GRAY CLINIC regardless of insurance coverage. I also understand that if my insurance company does not respond within 60 days, any fees for professional services still outstanding will be due and payable by me immediately.

Patient or Guardian Signature: **Date:**

3 ACCOUNT INFORMATION

OFFICE POLICY: I understand that the Gray Clinic requires full payment for all services when they are rendered unless prior arrangements have been made with the business manager. I also understand that if the GRAY CLINIC, as a convenience to me, decides to wait for payment from the Insurance Co., all services are charged directly to me and that I am ultimately responsible for their full payment. I understand that if I suspend or discontinue care at the GRAY CLINIC, any fees for professional services still outstanding will be due and payable immediately. I also agree that if my account is not paid in full within 90 days after being released, I am responsible for all fees necessary to collect my debt. These fees includes any billing fees, late fees, interest fees, attorney fees, or court fees.

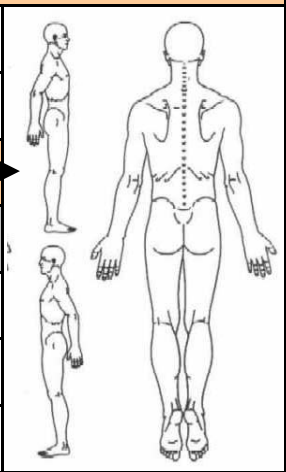
HIPPA: The patient understands and agrees to allow the GRAY CLINIC OF CHIROPRACTIC, Ltd. to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this 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 HIPPA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform this office. Thank you.

Patient or Guardian Signature: **Date:**

Please turn over and fill out the back side too.

4 CURRENT HEALTH INFORMATION

Where does it hurt	
How did this start	
Start Date	**Mark all areas of pain on the figure to the right:** →



How often does your pain occur	❑ Every day or more	❑ 2 to 6 times/week	❑ 1 to 5 times/month	❑ Less than 1x/month
Check the statement that best describes your worst pain	❑ The pain stops or alters how I do things ---------- examples might be: Problem with getting in/out of a car or bending to tie your shoe or turning your head fully.			
	❑ I have pain but it does not alters how I do things ---- examples might be: Even though I hurt, I can move normally or even though I hurt I can still do my job without hindrance.			
	❑ I only notice my pain when I am relaxing ---------- examples might be: At work or when I am having fun I don't feel any pain but when I get home and relax, my back or neck hurt.			

These pains prevents me from doing the following in my normal way	❑ Daily Living	❑ Getting In/Out of Car	❑ Putting on Clothes	❑ Using the bathroom	
		❑ Getting In/Out of Tub	❑ Putting on Shoes	❑ Using the phone	❑
	❑ Work Duties ❑				
	❑ Hobbies	❑ Walking	❑ Golf	❑ Bowling	❑ Gardening
		❑ Running	❑ Fishing	❑ Tennis	❑ Painting ❑

Have you been treated by any other professional for these problems	❑ No ❑ Yes - Who
Please list your current medications	

5 PAST HEALTH INFORMATION & HABITS

Please place an "X" in the "No" or "Yes" box to indicate if you have had any of the following problems:

No	Yes	Symptom	No	Yes	Symptom	No	Yes	Symptom	No	Yes	Symptom	No	Yes	Symptom
❑	❑	Arthritis	❑	❑	Allergies	❑	❑	Cancer	❑	❑	Chest Pains	❑	❑	Diabetes
❑	❑	Digestive Problems	❑	❑	Dizziness	❑	❑	Fainting	❑	❑	Headaches	❑	❑	Heart Attack
❑	❑	Heart Problems	❑	❑	Hernia	❑	❑	High Bld.Pres.	❑	❑	Low Bld.Pres.	❑	❑	Back Pain
❑	❑	Menstrual Cramps	❑	❑	Migraines	❑	❑	Seizures	❑	❑	Stroke	❑	❑	Ulcers

Please tell us about any past trauma/disease (include the date) you may have had or still do suffer from:

Surgeries	
Illnesses	
Accidents	
Other	

Please place an "X" in the box that best describes your lifestyle and habits:

EXERCISE	**Frequency:**	❑ None	❑ Off/On	❑ 2-3x/wk	❑ 4x+	**Type:**	❑ Walking	❑ Weights	❑			
HOBBIES	❑ None	❑ Golf	❑ Exercise	❑ Walking	❑ Gardening	❑ Reading	❑ Tennis	❑				
HABITS	❑ None	❑ Smoking: pks/day	❑ Alcohol: drinks/day	❑ Caffiene: cups/day	❑							
VITAMINS	❑ None	❑ Multi Vitamin - Brand:		❑ Calcium - Brand:		❑ C - Brand:						
	❑ Other:		❑ Other:			❑ Other:						

6 FAMILY HEALTH INFORMATION

Please tell about your family as this could tell us of potential problems you may suffer from:

FATHER		**BROTHER**	
MOTHER		**SPOUSE**	
SISTER		**CHILD**	

THANK YOU