Patient Health History

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name________________________ **Nick Name**________________________

Last Name ________________________ **Middle Name** ______________**Suffix** ________

Mailing Address____

City__________________________ **State**__________ **Zip Code** ______________

Primary Phone ____________________**Mobile Phone:**________________________

Home email ____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [. .] **Age** _______ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Spouse Name: ____

How/who referred you to our office? ____________________________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Current medications, including frequency/ dosage. If there are no medications, check here: ❑

1) ________________________ **5)** ________________________

2) ________________________ **6)** ________________________

3) ________________________ **7)** ________________________

4) ________________________ **8)** ________________________

List any known medication allergies. If no allergies are known, check here: ❑

1) ________________________ **3)** ________________________

2) ________________________ **4)** ________________________

Briefly list your main health (not only chiropractic) problems: ____________________

____

When was your last Chiropractic Adjustment:______________ **Name of D.C.** ______________

Emergency Contact: ________________________ **Phone#:** ______________

Social History: Circle the ones that currently apply:

Caffeine use occasionally   Caffeine used often   Chew tobacco occasionally   Chew tobacco often

Drink alcohol occasionally   Drink alcohol often

Exercise not at all   Exercise occasionally   Exercise often

Experience stress occasionally   Experience stress often

Wear seat belts always   Wear seat belts never   Wear seat belts usually

Family History: Circle the ones that apply:

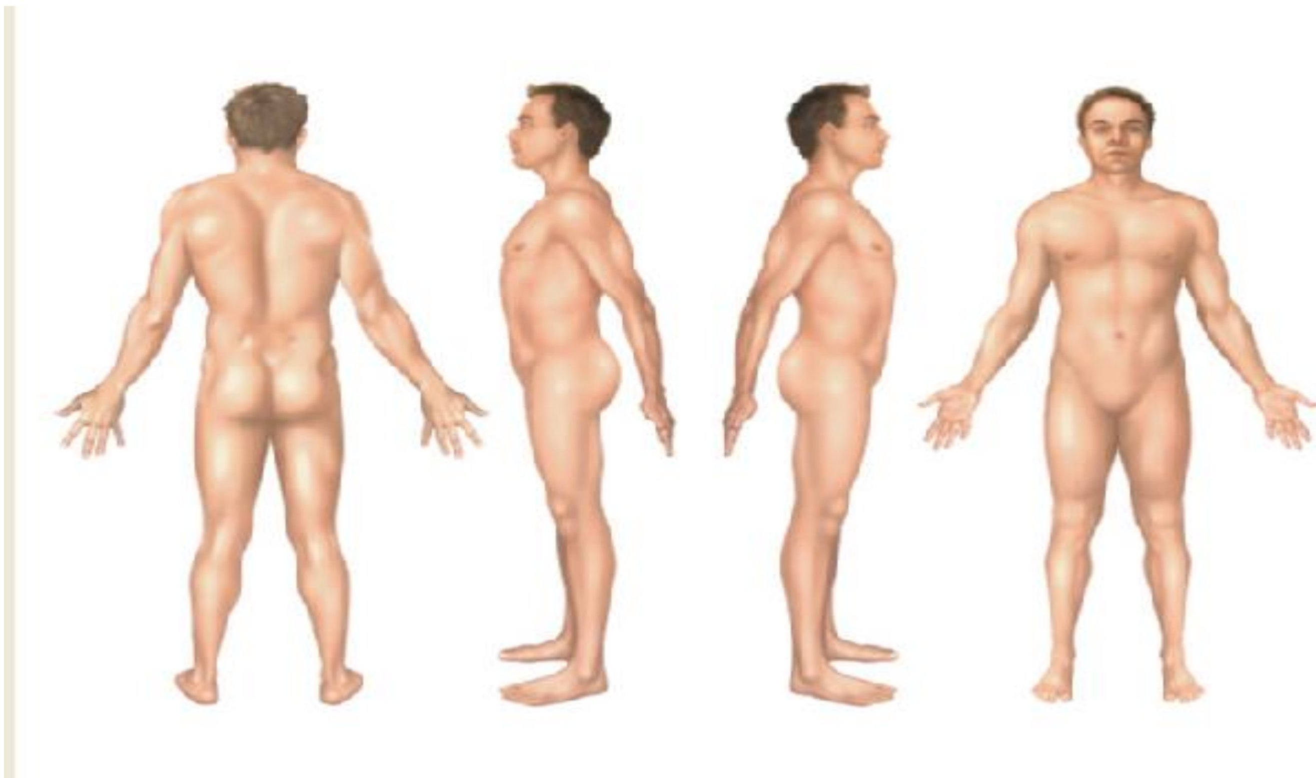
Arthritis (parent)   Arthritis (sibling)   Cancer (parent)   Cancer (sibling)   Cholesterol (parent)   Cholesterol (sibling)

Diabetes (parent)   Diabetes (sibling)   Heart problems (parent)   Heart problems (sibling)

High blood pressure (parent)   High blood pressure (sibling)   Psychiatric (parent)   Psychiatric (sibling)

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness   X = Burning   / = Stabbing   0 = Pins & Needles   + = Dull Ache   ^=Pain
Stroke (parent)   Stroke (sibling)   Thyroid (parent)   Thyroid (sibling)



Review of Systems:

Have you had trouble with any of the following IN THE LAST SIX MONTHS

Cardiovascular: No ______

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary: No ______

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic: No ______

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic: No ______

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			

Respiratory: No ______

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: No ______

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes: No ______

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: No ______

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric: No ______

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional: No ______

	Present	Past	No

Allergic/Immunologic: No ______

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal: No ______

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: No ______

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine: No ______

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

Spinning/Balance			
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Describe your symptoms:____

____

When did your symptoms start? Month____________________ **Day**________________ **Year**_______________

How did your symptoms begin?____

____

How often do you experience your symptoms?

❑Constantly (76-100% of the day)	❑Frequently (51-75% of the day)	❑Occasionally (26-50% of the day)	❑Intermittently (0-25% of the day)

What describes the nature of your symptoms?

❑Sharp	❑Dull ache	❑Numb	❑Shooting
❑Burning	❑Tingling	❑Stabbing	

How are your symptoms changing?

❑Getting better	❑Not changing	❑Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

❑0 None	❑1	❑2	❑3
❑4	❑5	❑6	❑7
❑8	❑9	❑10 Unbearable	

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

❑Not at all	❑A little bit	❑Moderately	❑Quite a bit
❑Extremely			

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

❑All of the time	❑Most of the time	❑Some of the time	❑A little of the time
❑None of the time			

In general, would you say your overall health right now is….

❑Excellent	❑Very good	❑Good	❑Fair
❑Poor			

Who have you seen for your symptoms:

❑No one	❑Other Chiropractor	❑Medical Doctor	❑Physical Therapist
❑Other			

What treatment did you receive for your symptoms?

❑Adjustments	❑Physical Therapy	❑Medication	❑Surgery
❑Other			

When did you receive this treatment?

❑In the last month	❑2 – 3 months ago	❑3 – 6 months ago	❑6 months to 1 year ago
❑1 – 2 years ago	❑2 – 5 years ago	❑5 – 10 years ago	

What tests have you had for your symptoms?

❑X-rays	❑MRI	❑CT Scan	❑Other

When were these tests done?

❑In the last month	❑2 – 3 months ago	❑3 – 6 months ago	❑6 months to 1 year ago
❑1 - 2 years ago	❑2 – 5 years ago	❑5 – 10 years ago	

Have you had similar symptoms in the past?

❑ Yes ❑ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

❑This Office	❑Other Chiropractor	❑Medical Doctor	❑Physical Therapist
❑Other			

What is your occupation?

❑Professional/Executive	❑White Collar/Secretarial	❑Tradesperson	❑Laborer
❑Homemaker	❑Full-time Student	❑Retired	❑Other

If you are not retired, a homemaker or a student, what is your work status?

❑Full-time	❑Part-time	❑Self-employed	❑Unemployed
❑Off work	❑Other		

*************************PAYMENT ASSIGNMENT POLICY***************************

Medicare/Medical Supplement Policies = We are a non-participating provider of Medicare and any Medicare Supplement Insurance Carriers. **HOWEVER, WE DO NOT ACCEPT PATIENTS WHO HAVE A PFFS MEDICARE PLAN**. Medicare will **only** reimburse you for your adjustments. **You will be responsible for paying for these services in full at the time the services are rendered or at the end of the week if multiple visits are required.** In turn, we will bill Medicare on a 14-21 day cycle as long as you are receiving chiropractic care in this office and Medicare should in turn reimburse you. We will also file your secondary insurance after we receive a statement from Medicare showing their payment. You should **receive reimbursement** from Medicare about **8-10 weeks** from the date we submit your claim.

______ Patient's initial ______ Witness initial

Commercial Insurance/Non-Insurance = We are a non-participating provider for all insurances (out of network).**Additionally we no longer accept Cigna Health Insurance or Blue Cross and Blue Shield of Tennessee (If the front of your card says 'Out of Network Benefits: None')**. **This means that we require payment for all services rendered at the time of service or at the end of each week if multiple visits are required**. As a service to you we will bill your insurance carrier (except for Cigna and BC/BS of TN plans with no out of network benefits) on a 14-21 day cycle and they in turn should reimburse you for what they may cover for out-of-network chiropractic. It's your responsibility to keep track of your reimbursements.

______ Patient's initial ______ Witness initial

***********************************APPOINTMENT POLICY*********************************

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. Because your condition may require numerous appointments over the next few weeks or months, we have designed a Multiple Appointment Program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, not the days on which you receive the service. If, for any reason, you are unable to keep an appointment, we require that you telephone immediately (931.484.8843) to reschedule that visit. It is the **patient's obligation** to **make up a missed appointment within 7 days of any cancellation.** Also, this office reserves the right to charge for missed appointments and those appointments cancelled without 24 hours notice.

When entering the office on any given visit, please go directly to the front desk and "sign-in". We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. You are welcome to call the office to check and see if the doctor is running on time for that day. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

Please sign here if you understand our "Appointment Policy"

Name: ______________________________________ Date: _______________

**************CONSENT TO EXAMINATION AND DIAGNOSTIC PROCEDURES************

I, ________________________________do hereby authorize the Gray Chiropractic Clinic, Doctors or assistants to perform upon me examination and diagnostic procedure arising from any current or presently unforeseen conditions, which the Gray Chiropractic Clinic, may consider necessary or advisable in the course of my health care.

I understand and agree that Gray Chiropractic Clinic has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Patient Signature: ______________________________________

Date: ______________________________________

Witness: ______________________________________
Printed Name

____
Signature

***CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION ***

Our Privacy Pledge
We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization
You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your Chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time(§164.524).

This notice is effective as of __________________. This authorization will expire seven years after the date on which you last received services from us.

☐ YES, I DO WANT A COPY OF THIS PAGE.

☐ NO, I DO NOT WANT A COPY THIS PAGE.

___________________________	______________________________
Patient Name Printed	Date
___________________________	______________________________
Patient Signature	Authorized Provider Representative
___________________________	______________________________
Personal Representative Printed	Personal Representative Signature

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Description of personal representative's authority to act for the patient