Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT GRACE FAMILY CHIROPRACTIC

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____ Mobile Phone:_____
Cellular provider _____

Marital Status: ☐ Single ☐ Married Social Security #: _____ Primary Care Physician: _____

Employer: _____ Occupation: _____ Work Phone: _____

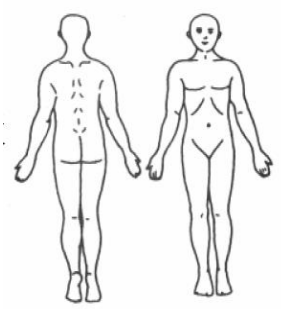
HEALTH HISTORY

Name of Previous Chiropractor: _____
☐ **N/A** If yes, when? _____

List any medications you are taking: _____

_____

PLEASE MARK the areas on the diagram to indicate area(s) of body with symptoms:



When did symptoms begin?
_____

CIRCLE one choice which most closely describes your condition now:

No pain	Mild pain	Moderate pain	Severe pain	Worst possible

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

□ Headaches	□ Pins and needles in legs	□ Fainting	□ Neck Pain
□ Pins and needles in arms	□ Loss of smell	□ Back Pain	□ Loss of balance
□ Dizziness	□ Buzzing in ears	□ Ringing in ears	□ Nervousness
□ Numbness in fingers	□ Numbness in toes	□ Loss of taste	□ Stomach upset
□ Fatigue	□ Depression	□ Irritability	□ Tension
□ Sleeping problems	□ Neck stiff	□ Cold hands	□ Cold Feet
□ Diarrhea	□ Constipation	□ Fever	□ Hot Flashes
□ Cold sweats	□ Lights bother eyes	□ Problem urinating	□ Heartburn
□ Mood swings	□ Menstrual pain	□ Menstrual irregularity	□ Ulcers

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further information

I hereby authorize payment to be made directly to Grace Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Grace Family Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

BC UHC Aetna Tufts Cigna Other Cash Medicare Medicare/Supp't MVA PI W/C

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and the interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express maximum health potential.

We do not offer to diagnose or to treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

HIPAA: We are very concerned about protecting the privacy of your records and personal health information. We will never release or share your records or information to any third party without your consent. In accordance with the Health Insurance Portability and Accountability Act of 1996 we are required to supply you with our privacy policies and procedures upon your request. We have a copy available in the reception area and if you would like to have one for your records please ask for a copy. This serves as acknowledgement of our HIPAA Privacy Practices for Protecting Health Information.

I, _____ have read and fully understand the above statements.
print name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____

Patient Signature Date

_____

Parent or Guardian Signature Date