Active Care Chiropractic • Dr. Eric McGraw, D.C.

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First Name:	Last Name:	Date:
Preferred Name:	Email:	
Home Phone:	Cell Phone:	Work Phone:
Address:	City, State:	Zip:
Social Security #:	Birth Date:	Age:
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed	Occupation:	
Employer:	Employer Phone:	
Names and Ages of Children:		
Spouse:	Occupation:	Employer:
Emergency Contact:	Phone Number:	
How were you referred to our office:		
Family Medical Doctor:	May We Update Your Doctor: ☐Yes ☐No	
Personal Trainer:	May we Update Your Personal Trainer: ☐Yes ☐No	

For your convenience we offer text message or email appointment reminders. Which would you prefer?

☐Text ☐Email ☐Both

Preferred Language: _____ ☐ I choose Not to Specify

Race: ☐American Indian ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Pacific Islander ☐ I Choose Not to Specify ☐Other _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐I Choose Not to Specify

Do you currently smoke tobacco of any kind? ☐ Yes ☐ No ☐ **Former Smoker** ☐ **Never Smoked**

If yes, how often do you smoke? ☐ Current Every Day Smoker ☐ Current Occasional Smoker

What is your level of interest in quitting smoking? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Interest Very Interested

Are You Currently Taking Any Medications? ☐Yes ☐No *(Please include regularly used over the counter medications)*

Medication Name	Dosage	Frequency	Additional Comments

Do You Have Any Medication Allergies? ☐Yes ☐No

Medication Name	Reaction	Onset Date	Additional Comments

Reason for Visit

Reason for Visit	When did this Start?	Did the issue start with injury?	Type of Injury
(Primary Concern) 1.			
2.			

Pain Scale - Check the box that most adequately describes your pain level

No Symptoms Extreme Symptoms

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

What is your major symptom?
Does this condition interfere with any part of the following? ☐Work ☐Driving ☐Standing ☐Climbing Stairs ☐Dressing ☐Sleep ☐Sports/Exercise ☐Walking ☐Reading/Studying ☐Sitting ☐Self-Care/Hygiene ☐Cooking ☐Cleaning ☐Working at Computer ☐Carrying Briefcase/Purse
How frequent is the problem? ☐Constant ☐Daily ☐Intermittent ☐Nightly
How long does it last? ☐All Day ☐A Few Hours ☐Minutes
Are there any other conditions/symptoms that are related to this problem?
Is the pain? ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing Other?
What helps relieve the problem?
What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting Other?
Women: Are you pregnant or may be pregnant? ☐Yes ☐No
Additional information that we should know:
Are you interested in learning more about nutrition and supplements? ☐Yes ☐No

Medical History

(Please select all that you have had or currently have)

☐Alcoholism	☐Circulatory Issues	☐Stroke	☐Erectile Dysfunction	☐Headaches
☐Back Pain	☐Arthritis	☐Swelling of Ankles	☐Gall Bladder	☐Low Blood Sugar
☐Diabetes	☐Seizures	☐Coughed Up Blood	☐Depression	☐Multiple Sclerosis
☐Gout	☐Congenital Disease	☐Eating Disorder	☐Ulcers	☐Thyroid Condition
☐Allergies	☐Excessive Bleeding	☐Drug Addiction	☐Heart Attack	☐Anemia
☐Cancer	☐Pace Maker	☐Mumps	☐Diarrhea	☐Plantar Fasciitis
☐Cold Extremities	☐Fatigue	☐Emphysema	☐Trouble Sleeping	☐Tuberculosis

☐Arteriosclerosis	☐Constipation	☐Digestion Problems	☐Heart Disease	☐Measles
☐Neck Pain	☐Rheumatic Fever	☐Incontinence	☐High Blood Pressure	☐Menstrual Cramps
☐Dizziness	☐Swollen Joints	☐Cramps	☐Frequent Urination	☐ Bruise Easily
☐Nervousness	☐Ringing in Ears	☐Sinus Problems	☐Asthma	
☐Other:				

Medical History (*continued)*

(Please select all that you have had or currently have)

Head-*Please select all that apply*

Headaches: How many per week?	☐Front ☐Side of Head ☐Behind Eyes ☐Back of Head
☐Morning ☐Afternoon ☐ Evening	☐Faintness ☐Vertigo ☐Poor Concentration ☐Confusion
☐Whiplash ☐Sluggish ☐Forgetfulness ☐Indecisive ☐Poor Memory ☐Face Twitch ☐Hair Loss ☐Concussion	
Other: (Please Explain)	

Nose -*Please select all that apply*

☐Allergies ☐Stuffy ☐Congested ☐Runny	Drainage: ☐Yellow ☐Green ☐Clear
☐Sinus Infection ☐Bleeding ☐Loss of Smell ☐Deviated Septum ☐Sneezing ☐Post Nasal Drip ☐Acute Smell	
Does change of seasons make symptoms worse? ☐Y ☐N	What season? ☐Spring ☐Summer ☐Fall ☐Winter
Other: (Please explain)	

Ears -*Please select all that apply*

☐Hearing Changes ☐Deafness ☐Hearing Aids ☐Ringing in Ears ☐Increased Ear Wax ☐Ear Infections
☐Swimmers Ear ☐Drainage ☐Aches ☐Itches ☐Pressure ☐Tubes in Ears
Other: (Please explain)

Neck -*Please select all that apply*

☐Pain ☐Stiffness ☐Whiplash ☐Swollen Glands ☐Bruit ☐Carotid Stenosis ☐Trouble Swallowing
☐Lumps ☐Numbness ☐Tingling in Hands ☐Muscle Spasms ☐Change in Range of Motion
Other: (Please explain)

Surgeries

Type	Body Part	Year

Social History

Alcohol: ☐Daily ☐Weekly ☐Occasionally ☐Never
Drugs: ☐Daily ☐Weekly ☐Occasionally ☐Never
Tobacco: ☐Daily ☐Weekly ☐Occasionally ☐Never
Processed, Packaged, & Restaurant Food: ☐Daily ☐Weekly ☐Occasionally ☐Never
Energy Products or Over the Counter Stimulants: ☐Daily ☐Weekly ☐Occasionally ☐Never

Caffeine: ☐Daily ☐Weekly ☐Occasionally ☐Never
Soft Drinks: ☐Daily ☐Weekly ☐Occasionally ☐Never
Exercise: ☐Daily ☐Weekly ☐Occasionally ☐Never
What are your hobbies?
What % of time during the day do you spend: Lifting? _____ Sitting? _____ Bending? _____ Working at Computer? _____

Family History

Please review the symptoms and conditions below. Indicate any current or past health problems of a family member. Leave blank those spaces that do not apply.

Condition	**Father** Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____ Age____		**Sister**(s) Age____ Age____		**Children** Age___ Age___ Age ___		
Name										
Allergies/Asthma										
Arthritis										
Arm/Leg Pain										
Cancer										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Headaches/Migraines										
Heart Disease										
High Blood Pressure										
Low Energy										
Neck/Back Pain										
Pinched Nerve										
Plantar Fasciitis										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Thyroid Problems										
Other:										

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to Active Care Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Our goal is to provide quality care in a timely manner. In order to do so, Active Care Chiropractic kindly requests 24 hours' notice for cancelled/rescheduled appointments. Cancelled/rescheduled appointments or appointments missed by a patient without 24 hours' notice will incur a $15 cancellation fee.

By signing you are agreeing to the statements above.

	Date:
ıre Authorizing Care:	**Date:**

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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 HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

PRIVACY INSTRUCTIONS May we discuss details regarding your care, your test results, billing information, or appointment information with someone else, other than you? Yes □ No □
If yes, please list the name and relationship of each individual below.

1. Name _____ Relationship _____
2. Name _____ Relationship _____

May we leave detailed messages on your answering machine or voice mail (e.g. test results, billing, etc.)?
Yes □ No □ If so, what phone number should we use for this purpose? _____

I acknowledge that I have received or have been offered a copy of the Notice of Patient Privacy Policy.

Printed Patient Name

Signature of Patient or Patient's Representative (if minor) **Date**

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Patient Name

Signature of Patient **Date**

Signature of Patient's Representative (if minor) **Date**