Patient History and Registration

Name: _____

Date:_____ Date of Birth: _____ Age:_____

Which physician are you here to see? (leave blank if unsure)
□ Dr. Brian Grindstaff, Chiropractor □ Dr. Sterling Foster, Chiropractor

Patient Condition

Reason for Visit / Primary Complaint: _____
When did this symptom begin?_____
Does the discomfort from this symptom seem to be getting worse? _____
On a scale of 1-10 (10 being worse), How would your rate your pain? _____
Is this from injury, if yes: _____

Health History

Mark if you have had any of the following:

- □ Headaches / Migraines
- □ Neck Pain and Stiffness
- □ Jaw Pain / TMJ
- □ Upper or Mid-Back Pain/Stiffness
- □ Shoulder Pain
- □ Elbow/Arm/Hand Pain
- □ Low Back Pain
- □ Hip / Leg / Knee Pain
- □ Tingling/Numbness
- □ Memory Loss
- □ Difficulty Walking
- □ Dizziness / Fainting
- □ Ringing in Ears
- □ Ear Infections
- □ Foot/Ankle Pain
- □ Sinus Trouble
- □ Shortness of Breath
- □ Anxiety / Depression
- □ Difficulty Sleeping
- □ Fatigue /Tiredness
- □ Nausea
- □ Diarrhea / Constipation
- □ Other Digestive Trouble
- □ Cold Hands/Feet
- □ Hypertension
- □ Heart Disease
- □ Arthritis
- □ Cancer
- □ Fibromyalgia
- □ Diabetes / Hypoglycemia
- □ Bowel / Bladder Problems
- □ Morning Stiffness
- □ Fever
- □ Weight Loss
- □ Muscle Spasms

What have you tried already? Medicine Surgery Physical Therapy Chiropractic TENS
ESI / Blocks Nothing Other _____
Have you been hospitalized from pain? Yes No If Yes, explain_____
Name and Phone Number of Medical Doctor: _____
Height: _____ Weight:_____

Please list the date of last:
Physical Exam_____ Spinal Exam _____ Blood Test _____
Chest X-ray_____ Spinal X-Ray_____ Urine Test _____
Dental X-ray_____ MRI / CT / Bone Scan _____
For Women: Are you Pregnant? Yes No Due Date _____
For Women: What is the date of your last Mammogram? _____
For Women: When was your last menstrual period? _____

Injuries and Surgeries
Falls _____
Head Injuries _____
Broken Bones _____
Dislocations _____
Hospitalizations _____
Surgeries _____
Have you ever been involved in a motor vehicle accident? If yes, please describe:_____
_____

Health History (cont.)

Do any of the following make the pain worse? (please circle all that apply)
Coughing Sneezing Sitting Standing Lying Down Walking Physical Activity
Other _____

Do any of the following make the pain better? (please circle all that apply)
Relaxation Sitting Standing Lying Down Alcoholic Drinks Heat / Cool Walking
Medicine Other _____

Is this injury from a work related accident? _____

Is this from an auto related accident? _____

Lifestyle (circle all that apply)

Exercise	*Work*	*Habits*
None	Sit	Smoke
Moderate	Stand	Alcohol
Daily	Light Labor	Coffee / Caffeine
Heavy	Heavy Labor	High Stress

Vitamins and Supplements (Please list all)

_____
_____
_____
_____

Medications (Please list all)

_____
_____
_____
_____
_____
_____

Allergies (Please list all)

_____
_____
_____

Family History

Cancer _____
Diabetes _____
Heart Disease _____
Spine Problems _____
Arthritis _____
Bleeding Disorders _____
Auto Immune _____
Mental Illness _____

Patient Information

Personal Information

Address: _____
City/State/Zip Code: _____
Home Phone: ( ) _____
Work Phone: ( ) _____
Cell Phone: ( ) _____
Mobile Carrier: _____
Email: _____
Age: _____Sex: M F Marital Status: S M D W
Patient's Soc. Sec. # _____
Occupation: _____
Employer's Name: _____
Work Address: _____
City/State/Zip Code: _____
Who may we thank for referring you / which event did you attend? _____

Demographic Information (Please circle)

Ethnicity: Hispanic/Latino Non-Hispanic/Latino
I decline to answer
Preferred Language: English Other_____
Race(s) American Indian Alaska Native Asian
Black/African American White
Native Hawaiian or other pacific islander
I decline to answer

Insurance Information (May we please copy your care with photo id)

Insured's Name _____
Insured's Soc. Sec. # _____
Relationship to Patient: _____
Insured's Date of Birth: _____
Insured's Employer: _____
Address _____
Phone number:_____

Emergency Contact Information

Name_____ Relationship: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Family Information

Spouse's Name: _____
Child's Name: _____ M F DOB_____
Child's Name: _____ M F DOB_____
Child's Name: _____ M F DOB_____

Authorization and Release *Please read and initial each line below and sign at the bottom.*

_____I hereby authorize **Integrated Spine & Joint, PLLC** to release information requested by my insurance carrier and/or Workers' Compensations carrier. Additionally, I authorize **Integrated Spine & Joint, PLLC** to release information to any hospital or physician I may be referred to by this health care provider.

_____I hereby acknowledge and authorize assignment and payment directly to **Integrated Spine & Joint, PLLC** of any major medical benefits and/or Medicare due me. I understand and acknowledge that insurance may not and that Medicare does not pay one hundred percent (100%) of the medical charges. I accept that I may need to sign an ABN form for future visits. I hereby acknowledge and agree to pay any and all charges that exceed or that are not covered by insurance and/or Medicare, including any deductible. I also acknowledge that I am responsible for reasonable interest, collection, fees, attorney fees of the greater of a) forty percent (40%) or b)$300.00 of the outstanding balance and/or court costs incurred in connection with any attempt to collect amounts I may owe.

_____Payment is due at the time services are provided. Every effort is made to bill most insurances. Your Cooperation is essential – please provide correct and current copies of any and all insurance cards. If there has been a change in you insurance, address, telephone number, and/or employment since your last visit, please notify the receptionist prior to being seen by the health care provider. If special arrangements are necessary, please speak with the office manager prior to being seen.

_____We want to thank you for choosing us as your health care provider. In order to provide you and our other patients with the best care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24-hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients. Our office does reserve the right to charge for a cancellation with less than a 24-hour notice and broken appointments. Thank you for your consideration of our policies.

Patient/Guardian Signature: _____ Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: