

Gray Chiropractic Center

Chris J. Dombrowski, D.C. Fran Dombrowski, D.C.
2 McConkey Rd., Suite 3, Gray, ME 04039
Ph: 207-657-5200 Fax: 207-657-5202

Payment Information

Name (first, middle, last): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email address: _____

If we need to contact you during the day, which number is best? Home Cell Work

Occupation: _____ Employer: _____

Date of Birth: _____ SS#: _____

Emergency contact: _____ Phone: _____

Insurance Carrier: _____ Policy Number: _____

Insured's Name: _____

Who carries this policy? Self Spouse Parent
(If spouse or parent, please provide their information below)

Policy Holder's Name _____ Date of Birth: _____

Policy Holder's SS#: _____ Policy Holder's Phone: _____

Policy Holder's Place of Employment: _____

I authorize my insurance company to pay this chiropractor/health center all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor/health center to release all information necessary to secure payment of benefits.

I understand I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Confidential Health History

Chiropractor's Notes

Please fill in the blanks or place an "X" on the circle the applies.

Name: _____ Birthdate: _____ Age: _____

Please describe the reason for your visit today. _____

- Is this the result of ("X" circle):
- An accident or injury
 - Work Auto
 - A worsening long-term problem
 - An interest in wellness
 - Other: _____

Where would you rate your pain at it's worst? 0 1 2 3 4 5 6 7 8 9 10
None Little Medium Severe

When did you first notice your current problem? _____

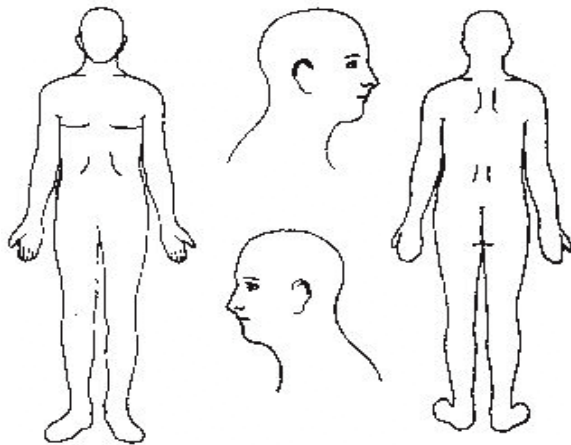
- How frequent is this condition? Constant Daily Night Only
- "Comes and Goes" Other: _____

Does the pain shoot or travel to any other area? _____

- What makes the problem worse (please "X" all that apply)? Standing
- Sitting Lying Bending Lifting Twisting Other: _____

Does anything make it better? _____

Please mark the location of your problem and check all words that apply:



- Throbbing
- Nagging
- Dull Ache
- Stabbing Pain
- Numbness
- Tingling
- Burning
- Sharp
- Deep Pressure
- Stiffness

Anything else we should know about your current condition? _____

Initials

Gray Chiropractic Center
2 McConkey Rd., Ste. 3
Gray, ME 04039
207-657-5200

Have you seen a chiropractor before? Yes No

Have you seen other doctors for this condition? Yes No

Have you been treated for any conditions by any physician in the last year?

Yes No Describe: _____

Review of Systems. Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please "X" any condition you have had (past or present).

- Osteoporosis
- Scoliosis
- Knee injuries/pain
- Foot/Ankle Pain
- TMJ
- Neck pain
- Hip issues
- Elbow/wrist pain
- Shoulder problems
- Back pain
- Anxiety
- Depression
- Headache
- Dizziness
- Pins and needles
- Numbness
- High blood pressure
- Low blood pressure
- High cholesterol
- Angina
- Poor circulation
- Excessive bruising
- Asthma
- Apnea
- Emphysema
- Hay fever
- Shortness of breath
- Pneumonia
- Ulcer
- Food sensitivities
- Heartburn
- Constipation
- Diarrhea
- Blurred vision
- Ringing in ears
- Hearing loss
- Chronic ear infections
- Loss of smell
- Loss of taste
- Cancer
- Psoriasis/Eczema
- Sudden weight change
- Acne
- Hair loss
- Frequent infections
- Thyroid issues
- Immune disorders
- Hypoglycemia
- Swollen glands
- Low energy
- Kidney stones
- Infertility
- Bedwetting
- Prostate issues
- PMS symptoms
- Poor appetite
- Fatigue
- Allergies
- AIDS
- Alcoholism
- Arthritis
- Diabetes
- Epilepsy
- Glaucoma
- Gout
- Heart Disease
- Stroke
- Tuberculosis
- Arteriosclerosis
- Multiple Sclerosis

Primary Physician's Name: _____ Phone: _____

Prescription or over-the-counter drugs you are taking: I'm not taking any

Name

DOB

DC Initials

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List all supplements you are taking: I am not taking supplements

Family History: Please list any chronic conditions or diseases that run in your family.

Condition	Relation (Dad, Mom or Sibling)
_____	_____
_____	_____

Social History: Please "X" any that apply.

Alcohol use : Daily Weekly Pain Relievers: Daily Weekly
Tobacco use: Daily Weekly Soft Drinks: Daily Weekly
Water intake: Glasses daily____ Coffee: Daily Weekly

Exercise: None Daily Weekly Moderate Heavy
Stress Level: Low Moderate High
Sleep: Back Side Stomach Average hours per night? _____
Work Activity: Sitting Standing Light Labor Heavy Labor

Name
DOB
DC Initials
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Activities of Daily Living. How does this condition currently interfere with your life and ability to function? Please place and "X" over each bubble that applies.

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery Shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising from chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering/bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love of life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Duties at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					

Acknowledgements

To the best of my ability the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I realize an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

Signature: _____ **Date:** _____

Gray Chiropractic Center

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Authorization for Release of Patient Information

Patient Name _____ Date of Birth _____

I hereby authorize _____
Name Address City State Zip

Telephone Number _____

to disclose the above named individual's health information as described below:

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

Most recent history and physical

Laboratory reports Consultations

Radiology/Imaging reports Progress notes

Radiology films Entire medical record

Other _____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used the following individual or organization:

Name Address City State Zip Phone

Description of the purpose of the use and/or disclosure:

Continuing Care Second Opinion Social Security/Disability

Consultation Insurance Other: Describe: _____

Legal purposes Personal Use _____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand The Gray Chiropractic Center may charge a processing fee for this service. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event).

I understand I may revoke this authorization at any time by notifying the Gray Chiropractic Center. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative Printed name of Patient or Patient's Representative

Relationship to Patient or Legal Authority (attach supporting documentation) Date

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Informed Consent for Chiropractic Care

It is important for you to understand the one and only goal of chiropractic care is to check the spine for Vertebral Subluxations and release them by means of chiropractic adjustments. We may use other adjunctive procedures designed to compliment the chiropractic care.

A **Vertebral Subluxation** is a slightly misaligned vertebra which interferes with the transmission of impulses over nerves, reducing the body's natural ability to maintain its own health. An **adjustment** is a force applied to the spine to release Vertebral Subluxations.

The examinations and office visits in this office are not done to detect, diagnose or treat any disease. An adjustment is not meant to be a cure for all disease or a specific treatment for any particular disease. Chiropractic is not a substitute for other types of health care, just as other types of care do not take the place of chiropractic.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per million to one per two million neck adjustments may be vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to detect Vertebral Subluxations and determine if there is any reason to modify your care or refer you to another health care provider.

I understand and accept there are risks associated with chiropractic care and give my consent to the examinations the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)

Patient or legal Guardian signature

Date

Witness Signature (office staff)

Date



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Notice of Privacy Practice Summary

This form discloses how health information about you may be used. A full notice of your privacy rights can be provided to you.

Gray Chiropractic Center uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Gray Chiropractic Center will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Gray Chiropractic Center may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Gray Chiropractic Center may disclose your information for public health activities, health and safety, governmental function and in order to comply with workers compensation laws and regulations.

You have the right to request restrictions, retain a copy of your health records, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Gray Chiropractic Center must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of this notice, and notify you if we are unable to agree to the requested restriction on how your information is used or disclosed.

Gray Chiropractic Center will accommodate reasonable requests you may make to communicate your health information by alternative means or from alternative locations.

If you have any questions or complaints, please contact Gray Chiropractic Center.

Patient Signature

Date