# 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**

**Date of Birth:** _____ **Occupation:** _____

**Emergency contact:** _____ **Phone:** _____**Relationship**_____

**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 _____

## Health History

Please fill in the blanks or place an "X" on all circles that apply.

Name: _____ Birthdate: _____Age: ___

Please describe the reason for your visit today. _____

_____

Is this problem the result of: ○ A work injury ○ An auto accident

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? ○ Daily ○ Weekly ○ Night Only

Is your condition: ○ Constant ○ Frequent ○ Intermittent ○ Occasional

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

What makes it worse? ○ Sitting ○ Standing ○ Walking ○ Bending

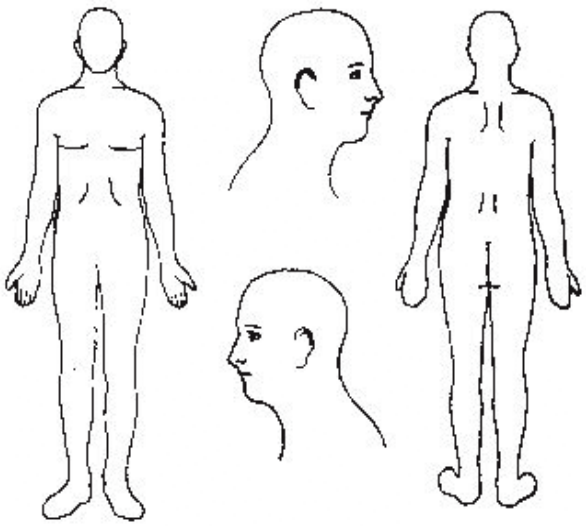
○ Lifting ○ Sleeping/Laying ○ Sneezing/Coughing ○ Reaching

○ Twisting ○ Looking Up/Down ○ Driving ○ Movement ○ Stairs

Other: _____

Does anything make it better? _____

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



- ○ Dull Ache
- ○ Tingling
- ○ Sharp
- ○ Stabbing Pain
- ○ Throbbing
- ○ Cramping
- ○ Burning
- ○ Numbness
- ○ Deep
- ○ Stiffness

Anything else we should know about your current condition?

_____

_____

Chiropractor's Notes

_____
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 anyone else for this condition? ○ Yes ○ No

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

○ Yes ○ No Describe:_____

**Review of systems:**

Do you experience problems in the following systems?

| | Yes | No |
|---|---|---|
| Musculoskeletal (bones, joints, posture, TMJ, etc.) | ○ | ○ |
| Neurological (dizziness, tingling, numbness) | ○ | ○ |
| Cardiovascular (blood pressure, circulation) | ○ | ○ |
| Respiratory (lungs, allergies, breathing) | ○ | ○ |
| Digestive (stomach, digestion, colon, bloating, gas) | ○ | ○ |
| Sensory (eyes, ears, smell, taste) | ○ | ○ |
| Integumentary (skin, hair, nails, eczema, psoriasis) | ○ | ○ |
| Endocrine (thyroid, low energy, poor sleep) | ○ | ○ |
| Genitourinary (kidney, bladder, prostate) | ○ | ○ |
| Constitution (appetite, fatigue, weight change) | ○ | ○ |

Primary Physician's Name: _____Phone: _____

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

_____

_____

_____

Do you take vitamins/herbs/homeopathy? ○ Yes ○ No

**Past Personal History**:

Have you ever had any of the following problems? ○ Arthritis ○ Cancer
○ Diabetes ○ Frequent Constipation ○ Frequent Headaches ○ Stroke
○ Heart Disease ○ High Blood Pressure ○ Osteopenia/Osteoporosis

Have you had any operations, which may or may not have included hospitalization?
○ Yes ○ No List:_____

Have you had any accidents or injuries, such as:
○ Broken bones ○ Been knocked unconscious ○ Been in any auto accident
○ Concussion ○ Other: _____

Name

DOB

DC Initials

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_____
Name/DOB

_____
DC Initials

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## Family History:

Are there problems that run in your family?

○ Cancer ○ Diabetes ○ High Blood Pressure Other: _____

## Social History:

Alcohol use ○ None ○ Occasional ○ Weekly/Drinks per week _____

Tobacco use ○ Yes ○ No

Exercise ○ Regularly ○ Sometimes ○ Never

Stress Level ○ Low ○ Moderate ○ High

Sleep ○ Back ○ Side ○ Stomach Average hours per night? _____

Work Activity: ○ Sitting ○ Standing ○ Light Labor ○ Heavy Labor

## 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 |
|---|---|---|---|---|---|---|---|---|---|
| Personal Care | ○ | ○ | ○ | ○ | Driving/Traveling | ○ | ○ | ○ | ○ |
| Lifting | ○ | ○ | ○ | ○ | Duties at work | ○ | ○ | ○ | ○ |
| Walking | ○ | ○ | ○ | ○ | Concentration | ○ | ○ | ○ | ○ |
| Sitting | ○ | ○ | ○ | ○ | Recreation | ○ | ○ | ○ | ○ |
| Rising from Chair | ○ | ○ | ○ | ○ | Exercising | ○ | ○ | ○ | ○ |
| Standing | ○ | ○ | ○ | ○ | Caring for family | ○ | ○ | ○ | ○ |
| Sleeping | ○ | ○ | ○ | ○ | Yard/Housework | ○ | ○ | ○ | ○ |
| Using a computer | ○ | ○ | ○ | ○ | Reading | ○ | ○ | ○ | ○ |

**I realize an X-ray examination may be hazardous to an unborn child. I certify to the best of my knowledge that:**

○ I am not pregnant.

○ I am pregnant.

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

**Acknowledgement**

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

**Signature: _____ 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 your 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 done to detect and correct 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 course of care.

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I understand and accept there are risks associated with chiropractic care and give my consent to the examinations and spinal adjustments the doctor deems necessary.

_____
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 or for administrative purposes.
- 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 text appointment reminders, birthday greetings, 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, revoke your authorization and request an accounting of your health records.

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

We may use or disclose your health information to provide legally required notices of unauthorized access to (data breach) or disclosure of your health information.

If you paid out-of-pocket in full for a specific item or service and we did not bill your health plan, you have the right to ask that your health information with respect to that item or service not be disclosed to the health plan for purposes of payment or health care operations, and we will honor that request.

You may complain to our Privacy Officer and to the Department of Health and Human Services, 200 Independence Ave, SW, Washington, DC 20201, (202)619-0257 or go to the website of Civil Rights, www.hhs.gov/ocr/hipaa/ for more information 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.

We will not sell your health information.

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

_____  _____

Patient Signature  Date