GRIEB
CHIROPRACTIC CLINIC

Today's Date

Your Last Name | Your First Name | Middle Initial | Date of Birth

**Marital Status:** ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Spouse's Name (if applicable) | Number of Children (if applicable)

Address | City

State | Zip Code

Phone Number | Email Address

Your Occupation | Your Employer

Emergency Contact | Phone Number

**How can we help you today?**

**How did you hear about us?** ◯ Google ◯ Location ◯ Referred by: _____

## Review of Systems: *Circle all that apply and explain below if indicated.*

**Musculoskeletal System:** arthritis, fractures, gout, osteoporosis, surgical hardware, TMJ disorder.
**Neurological System:** anxiety, depression, dizziness, epilepsy, headaches, migraines, numbness, stroke, weakness.
**Cardiovascular System:** heart attack, high cholesterol, hypertension, hypotension, pacemaker.
**Gastrointestinal System:** colitis, colon cancer, diverticulitis, reflux, pancreatitis.
**Endocrine System:** diabetes, steroid treatments, thyroid problems.
**Genitourinary System:** bed wetting, ectopic pregnancy, infertility, kidney stones, PCOS, prostate issues, PMS symptoms.
**Respiratory System:** Asthma, COPD, emphysema, tuberculosis.
**Lymphatic System:** swelling or pain in lymph nodes of the axillae, groin, neck, and other areas.
**Immunological System:** ankylosing spondylitis, lupus, multiple sclerosis, psoriatic arthritis, rheumatoid arthritis.
**Explain above/other present illness:**_____
_____.
**Current Medications:**_____
_____.

## Acknowledgement:

To set clear expectations, improve communication, and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials_____ **I am aware of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials_____ **I acknowledge that Grieb Chiropractic Clinic may recommend that X-Rays be taken so that a complete study and analysis may be made of my present condition. Therefore, Grieb Chiropractic Clinic is hereby authorized and directed to complete a radiographic examination in order to treat my present condition. To the best of my knowledge, I am not pregnant and Grieb Chiropractic Clinic has my permission to X-Ray me for diagnostic interpretation.**

Initials_____ **I acknowledge that any insurance I may have, is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I authorize assignment and direct payment of any medical expense allowable to the provider as payment toward the total charges for professional services rendered.**

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

_____ _____

**Signature (Patient/Parent/Guardian)** **Date**

I hereby request and consent to the performance of procedures, including various modes of physiotherapy, chiropractic adjustments, examinations, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Grieb Chiropractic Clinic and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers named below, including those working at the clinic or office listed below and any office or clinic, whether signatories to this form or not.

I understand and am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, and soreness. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

**Name of Patient: _____ Date_____**

**Signature of Patient or Parent/Guardian: _____**

**Name Printed of Parent/Guardian: _____**