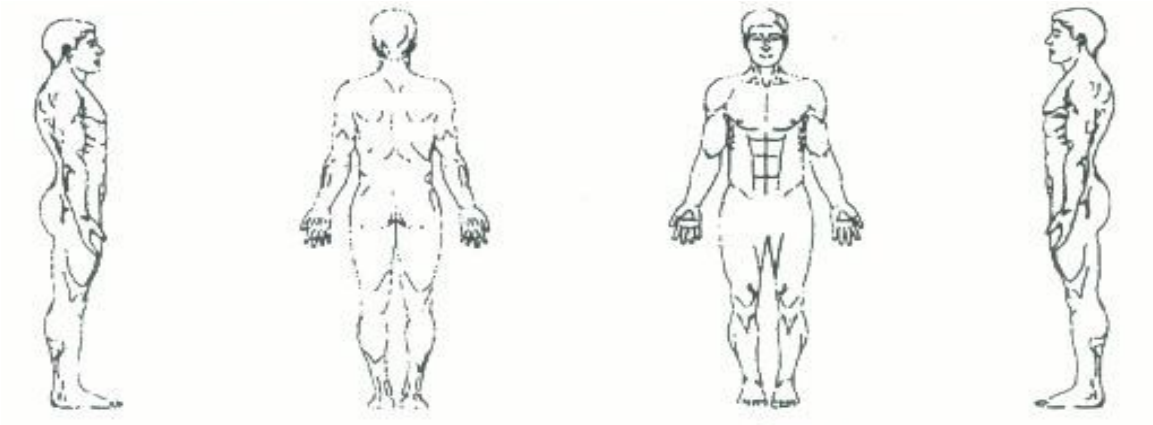
Name_____ Patient ID #_____ Date_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____ Text Message ☐Yes ☐No
E-mail _____ Social Security #_____ Driver Lic. #_____
Age_____ Birthdate_____/_____/_____ Sex M / F Status M S W D No.Children_____
Occupation_____ Employer_____Wk Phone_____Yrs Employed_____
Employer Address_____ City_____ State_____ Zip_____
Spouse's Name_____ Occupation_____ Employer_____
Health Insurance Subscriber Name_____ ID #_____ Group #_____
PLEASE DESCRIBE YOUR CURRENT PROBLEM._____
_____
HOW DID YOUR PROBLEM BEGIN?_____
DATE PROBLEM BEGAN:_____/_____/_____
WHAT TREATMENT HAVE YOU HAD FOR THIS PROBLEM IN THE PAST? (SURGERY, MEDICATIONS, INJECTIONS, PHYSICAL THERAPY, CHIROPRACTIC)_____
_____
HAVE YOU HAD X-RAYS, MRI, OR OTHER TESTS FOR THIS PROBLEM? WHAT TESTS AND WHEN?_____
_____
HAVE YOU BEEN UNDER PREVIOUS CHIROPRACTIC CARE? ☐YES ☐NO IF YES, PLEASE LIST_____
_____
WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)?_____
WHO REFERRED YOU TO GRIEB CHIROPRACTIC CLINIC?_____
CONTACT PREFERANCE ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

How bad is your pain? (Circle the number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms?	☐ Constantly	☐ Frequently	☐ Occasionally ☐ Intermittently
Describe your current pain/symptoms:	☐ Sharp/Stabbing	☐ Throbbing	☐ Aches
	☐ Dull	☐ Soreness	☐ Weakness
	☐ Numbness	☐ Shooting	☐ Gripping
	☐ Burning	☐ Tingling	☐ Other_____
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change
What makes it better?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ Inactivity/Rest	☐ Other_____
What makes it worse?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ Inactivity/Rest	☐ Other_____
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occationally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting	☐ Light labor	☐ Heavy labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High



Patient Signature_____ Date_____

Name_____ Patient ID #_____ Date_____

GRIEB
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If you have ever had a listed symptom in the past, please check the symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the Present Column. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT / THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Angina
☐	☐	Anorexia
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Cancer, Explain_____
☐	☐	Chest Pains
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Colitis
☐	☐	Constipation/Irregular Bowel Habits
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty in Swallowing
☐	☐	Dizziness
☐	☐	Emphysema
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Excessive Thirst
☐	☐	Fainting
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Hand Pain ☐ Left ☐ Right
☐	☐	Headache
☐	☐	Heart Attack Date_____
☐	☐	Heartburn/Indigestion
☐	☐	Hepitis
☐	☐	High Blood Pressure
☐	☐	Irregular Menstral Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain
☐	☐	Kidney Disorder
☐	☐	Kidney Stones
☐	☐	Liver/Gall Bladder Problems
☐	☐	Loss of Appetite
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Muscular Incoordination
☐	☐	PMS
☐	☐	Profuse Menstral Flow

Past	Present	Condition		
☐	☐	Low Back Pain		
☐	☐	Mid Back Pain		
☐	☐	Neck Pain		
☐	☐	Pain in Ankle or Foot	☐ Right	☐ Left
☐	☐	Pain in Lower Leg/Knee	☐ Right	☐ Left
☐	☐	Pain in Upper Arm/Elbow	☐ Right	☐ Left
☐	☐	Pain in Upper Leg/Hip	☐ Right	☐ Left
☐	☐	Pain in Upper Leg/Hip	☐ Right	☐ Left
☐	☐	Shoulder Pain	☐ Right	☐ Left
☐	☐	Wrist Pain	☐ Right	☐ Left
☐	☐	Rapid Heart Beat		
☐	☐	Rheumatoid Arthritis		
☐	☐	Scoliosis		
☐	☐	Stroke Date_____		
☐	☐	Swelling/Stiffness of Joints		
☐	☐	Tinnitus (Ear Noise)		
☐	☐	Tumor Explain_____		
☐	☐	Ulcer		
☐	☐	Visual Disturbances		
☐	☐	Other_____		

Please Check any of the following that apply to you

☐	☐	Pregnancy, Number of Births_____
☐	☐	Birth Control Pills, Type_____
☐	☐	Medications, Please List_____
		_____
		_____
☐	☐	Hospitalization/Surgical Procedures, Please List
		_____
		_____
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drugs or Alcohol Dependence
☐	☐	Coffee/Tea/Caffinated Soft Drinks, # Per Day_____

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Pain
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other _____
☐ High Blood Pressure	

Do you have allergies to medications?	☐ Yes	☐ No	
Do you have advanced directives?	☐ Yes	☐ No	
In an emergency, would you want CPR?	☐ Yes	☐ No	
In an emergency, would you want life support?	☐ Yes	☐ No	
Do you have a permanent disability rating?	☐ Yes	☐ No	Date received_____ Percentage_____
Pediatric Records (17 and younger) Are your immunizations up to date?	☐ Yes	☐ No	Please proved a complete record.

Present Weight_____ lbs Height_____ft/in

I certify that the above information is complete and accurate to the best of my knowlecge. I agree to notify this doctor immediately whenever I have a change in my health condition or health plan coverages in the future.

Patient Signature_____ Date_____

Name_____ Patient ID #_____ Date_____

GRIEB
CHIROPRACTIC CLINIC

Authorization To Perform X-Rays

This is to acknowledge that Grieb Chiropractic Clinic has recommended 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.

Executed this the _____ day of _____, 20___

Signed_____

Witness_____

Consent For Treatment

I hereby give consent to Grieb Chiropractic Clinic to administer whatever treatment is deemed necessary to treat my condition.

Executed this the _____ day of _____, 20___

Signed_____

Witness_____

Authorization To Release Information

I hereby authorize the doctor and his staff of Grieb Chiropractic Clinic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process and claim for the reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

Executed this the _____ day of _____, 20___

Signed_____

Witness_____

Notice Of Assignment

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of the agreement shall serve as the original.

Executed this the _____ day of _____, 20___

Signed_____

Witness_____

GRIEB
CHIROPRACTIC CLINIC

HIPPA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
Grieb Chiropractic Clinic

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Grieb Chiropractic Clinic's "NOTICE OF PRIVACY PRACTICES," revision date April 1, 2001.

As required by the Privacy Regulations, _____ from Grieb Chiropractic Clinic has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Grieb Chiropractic Clinic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

REQUESTS:

☐ I wish to file a "Request for Restiction" of my Protected Health Information

☐ I wish to file a "Request for Alternative Communication" of my Protected Health Information

☐ I wish to object to the following in the "Notice of Privacy Practices."

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Patient Signature_____ Date_____

Print Name_____

Signed form received by:_____

Good faith effort to obtain receipt: _____