

**Active Care Chiropractic • Dr. Eric McGraw, D.C.**

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First Name:		Last Name:		Date:
Preferred Name:			Email:	
Home Phone:		Cell Phone:		Work Phone:
Address:			City, State:	
Social Security #:			Birth Date:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Occupation:	
Employer:			Employer Phone:	
Names and Ages of Children:				
Spouse:		Occupation:		Employer:
Emergency Contact:			Phone Number:	
How were you referred to our office:				
Family Medical Doctor:			May We Update Your Doctor: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Personal Trainer:			May we Update Your Personal Trainer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
For your convenience we offer text message or email appointment reminders. Which would you prefer? <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Both				

<b>Preferred Language:</b> _____ <input type="checkbox"/> I choose Not to Specify <b>Race:</b> <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> I Choose Not to Specify <input type="checkbox"/> Other _____ <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> I Choose Not to Specify <b>Do you currently smoke tobacco of any kind?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoked If yes, how often do you smoke? <input type="checkbox"/> Current Every Day Smoker <input type="checkbox"/> Current Occasional Smoker What is your level of interest in quitting smoking? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <div style="display: flex; justify-content: space-between;"> <span>No Interest</span> <span>Very Interested</span> </div>
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**Are You Currently Taking Any Medications?**  Yes  No *(Please include regularly used over the counter medications)*

Medication Name	Dosage	Frequency	Additional Comments

**Do You Have Any Medication Allergies?**  Yes  No

Medication Name	Reaction	Onset Date	Additional Comments

## Reason for Visit

Reason for Visit	When did this Start?	Did the issue start with injury?	Type of Injury
1. (Primary Concern)			
2.			

### Pain Scale - Check the box that most adequately describes your pain level

No Symptoms	Extreme Symptoms
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
0   1   2   3   4   5   6   7   8   9   10	

What is your major symptom?
Does this condition interfere with any part of the following?
<input type="checkbox"/> Work <input type="checkbox"/> Driving <input type="checkbox"/> Standing <input type="checkbox"/> Climbing Stairs <input type="checkbox"/> Dressing <input type="checkbox"/> Sleep <input type="checkbox"/> Sports/Exercise <input type="checkbox"/> Walking <input type="checkbox"/> Reading/Studying <input type="checkbox"/> Sitting <input type="checkbox"/> Self-Care/Hygiene <input type="checkbox"/> Cooking <input type="checkbox"/> Cleaning <input type="checkbox"/> Working at Computer <input type="checkbox"/> Carrying Briefcase/Purse
How frequent is the problem? <input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Intermittent <input type="checkbox"/> Nightly
How long does it last? <input type="checkbox"/> All Day <input type="checkbox"/> A Few Hours <input type="checkbox"/> Minutes
Are there any other conditions/symptoms that are related to this problem?
Is the pain? <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Stabbing    Other?
What helps relieve the problem?
What makes the problem worse? <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Lying <input type="checkbox"/> Bending <input type="checkbox"/> Lifting <input type="checkbox"/> Twisting    Other?
Women: Are you pregnant or may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Additional information that we should know:
Are you interested in learning more about nutrition and supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Medical History

(Please select all that you have had or currently have)

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Circulatory Issues	<input type="checkbox"/> Stroke	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Headaches
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Swelling of Ankles	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Low Blood Sugar
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Coughed Up Blood	<input type="checkbox"/> Depression	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Gout	<input type="checkbox"/> Congenital Disease	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Allergies	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Anemia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Mumps	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Plantar Fasciitis
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Incontinence	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Cramps	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Other:				

**Medical History** *(continued)*  
**(Please select all that you have had or currently have)**

**Head** -Please select all that apply

Headaches: How many per week?	<input type="checkbox"/> Front	<input type="checkbox"/> Side of Head	<input type="checkbox"/> Behind Eyes	<input type="checkbox"/> Back of Head
<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening	<input type="checkbox"/> Faintness	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Whiplash	<input type="checkbox"/> Sluggish	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Indecisive	<input type="checkbox"/> Poor Memory
<input type="checkbox"/> Face Twitch				
<input type="checkbox"/> Hair Loss				
<input type="checkbox"/> Concussion				
Other: (Please Explain)				

**Nose** -Please select all that apply

<input type="checkbox"/> Allergies	<input type="checkbox"/> Stuffy	<input type="checkbox"/> Congested	<input type="checkbox"/> Runny	Drainage:	<input type="checkbox"/> Yellow	<input type="checkbox"/> Green	<input type="checkbox"/> Clear
<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Deviated Septum	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Post Nasal Drip	<input type="checkbox"/> Acute Smell	
Does change of seasons make symptoms worse? <input type="checkbox"/> Y <input type="checkbox"/> N				What season? <input type="checkbox"/> Spring			
				<input type="checkbox"/> Summer			
				<input type="checkbox"/> Fall			
				<input type="checkbox"/> Winter			
Other: (Please explain)							

**Ears** -Please select all that apply.

<input type="checkbox"/> Hearing Changes	<input type="checkbox"/> Deafness	<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Increased Ear Wax	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Swimmers Ear	<input type="checkbox"/> Drainage	<input type="checkbox"/> Aches	<input type="checkbox"/> Itches	<input type="checkbox"/> Pressure	<input type="checkbox"/> Tubes in Ears
Other: (Please explain)					

**Neck** -Please select all that apply

<input type="checkbox"/> Pain	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Whiplash	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Bruit	<input type="checkbox"/> Carotid Stenosis	<input type="checkbox"/> Trouble Swallowing
<input type="checkbox"/> Lumps	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling in Hands	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Change in Range of Motion		
Other: (Please explain)						

**Surgeries**

Type	Body Part	Year

**Social History**

Alcohol: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Drugs: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Tobacco: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Processed, Packaged, & Restaurant Food: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Energy Products or Over the Counter Stimulants: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Caffeine: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Soft Drinks: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
Exercise: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Never
What are your hobbies?
What % of time during the day do you spend: Lifting? _____ Sitting? _____ Bending? _____ Working at Computer? _____

# Family History

Please review the symptoms and conditions below. Indicate any current or past health problems of a family member. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
	Age____	Age____	Age____	Age____	Age____	Age____	Age____	Age____	Age____	Age____
<b>Name</b>										
Allergies/Asthma										
Arthritis										
Arm/Leg Pain										
Cancer										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Headaches/Migraines										
Heart Disease										
High Blood Pressure										
Low Energy										
Neck/Back Pain										
Pinched Nerve										
Plantar Fasciitis										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Thyroid Problems										
Other:										

## AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to Active Care Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Our goal is to provide quality care in a timely manner. In order to do so, Active Care Chiropractic kindly requests 24 hours' notice for cancelled/rescheduled appointments. Cancelled/rescheduled appointments or appointments missed by a patient without 24 hours' notice will incur a \$15 cancellation fee.

By signing you are agreeing to the statements above.

<b>Printed Patient Name</b>	
<b>Patient Signature</b>	<b>Date:</b>
<b>Patient's Representative Signature Authorizing Care:</b>	<b>Date:</b>



# Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**PRIVACY INSTRUCTIONS** May we discuss details regarding your care, your test results, billing information, or appointment information with someone else, other than you? Yes  No

If yes, please list the name and relationship of each individual below.

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

May we leave detailed messages on your answering machine or voice mail (e.g. test results, billing, etc.)?

Yes  No  If so, what phone number should we use for this purpose? \_\_\_\_\_

I acknowledge that I have received or have been offered a copy of the Notice of Patient Privacy Policy.

\_\_\_\_\_  
**Printed Patient Name**

\_\_\_\_\_  
**Signature of Patient or Patient's Representative (if minor)**

\_\_\_\_\_  
**Date**



## Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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**Printed Patient Name**

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**Signature of Patient**

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**Date**

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**Signature of Patient's Representative (if minor)**

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**Date**