GRAY CHIROPRACTIC HEALTH CLINIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

DATE: _____

PATIENT: _____

ADDRESS: _____

_____

city state zip

SEX: __ M __ F AGE: _____ BIRTHDATE:____/____/____

__SINGLE __MARRIED __WIDOWED __SEPARATED __DIVORCED

PATIENT SS#: _____

OCCUPATION: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

SPOUSE'S INFORMATION

NAME: _____

BIRTHDATE:____/____/____ SS#: _____

OCCUPATION: _____

EMPLOYER: _____

WHOM MAY WE THANK FOR REFERRING YOU?

_____

2 INSURANCE

WHO IS RESPONSIBLE FOR THE ACCOUNT?

_____

RESPONSIBLE PARTIES SS#: _____

RESPONSIBLE PARTIES BIRTHDATE: :____/____/____

RELATIONSHIP TO PATIENT: _____

INSURANCE CO.: _____

MEMBER NUMBER#: _____

GROUP #: _____

IS PATIENT COVERED BY SECONDARY INSURANCE? ___ YES ___ NO

IF YES:

RESPONSIBLE PARTIES NAME: _____

RESPONSIBLE PARTIES SS#: _____

RESPONSIBLE PARTIES BIRTHDATE: :____/____/____

RELATIONSHIP TO PATIENT: _____

INSURANCE CO.: _____

MEMBER NUMBER#: _____

GROUP #: _____

ASSIGNMENT AND RELEASE:

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO GRAY CHIROPRACTIC HEALTH CLINIC: DR. JENNIFER WALDROUP GRAY AND DR. CHARLIE GRAY ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE the DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURACE SUBMISSIONS.

_____

RESPONIBLE PARTIES SIGNATURE **DATE**

RELATIONSHIP TO PATIENT: _____

3 PHONE NUMBERS

HOME: _____ CELL: _____

WORK: _____ EXT: _____

EMAIL: _____

IN CASE OF EMERGENCY, CONTACT:

NAME: _____

RELATIONSHIP TO PATIENT: _____

HOME: _____ CELL: _____

WORK: _____ EXT: _____

4 ACCIDENT INFORMATION

IS THIS CONDITION DUE TO AN ACCIDENT? ___ NO ___ YES.....DATE: _____

TYPE OF ACCIDENT: ___ AUTO ___ WORK ___ HOME ___ OTHER

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT? ___ AUTO INSURANCE ___ EMPLOYER ___WORKER COMP.

OTHER: _____

ATTORNEY NAME & CONTACT INFORMATION (IF APPLICABLE): _____

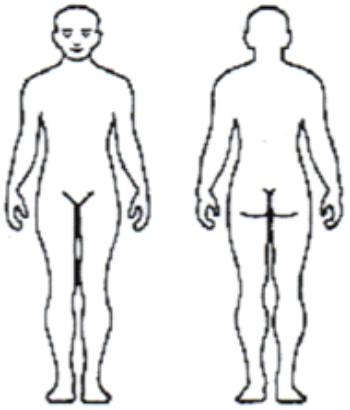
5 PATIENT CONDITION

REASON FOR VISIT: _____

WHEN DID YOUR SYMPTOMS APPEAR? _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ___ YES ___ NO

MARK AN 'X' ON THE PICTURE WEHRE YOU CONTINUE TO HAVE PAIN, NUMBNESS OR TINGLING.



RATE THE SEVERITY OF YOUR PAIN ON A SCALE OF 1 (LEAST PAIN) TO 10 (SEVER PAIN): _____

TYPE OF PAIN: __ SHARP __ DULL __ THROBBING __ NUMBNESS __ ACHING __SHOOTING

__ BURNING __ TINGLING __ CRAMPS __ STIFFNESS __ SWELLING OTHER:_____

HOW OFTEN DO YOU HAVE THIS PAIN? _____

IS IT CONSTANT OR DOES IT COME AND GO? _____

DOES IT INTERFERE WITH: __ WORK __ SLEEP __DAILY ROUTINE __ RECREATION

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PREFORM: __ SITTING __ STANDING __WALKING __BENDING __ LYING DOWN

6 HEALTH HISTORY

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOUR CONDITION (check all that apply)?

__ MEDICATIONS __ SURGERY __ PHYSICAL THERAPY __ CHIROPRACTIC SERVICES __ NONE __OTHER: _____

NAME AND ADDRESS OF OTHER DOCTOR(S) WHO HAVE TREATED YOU FOR YOUR CONDITION: _____

_____

DATE OF LAST: PHYSICAL EXAM _____ SPINAL X-RAY _____ BLOOD TEST _____

SPINAL EXAM _____ CHEST X-RAY _____ URINE TEST _____

DENTAL X-RAY _____ MRI, CT-SCAN, BONE SCAN _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV	__YES	__NO	EPILEPSY	__YES	__NO	MUMPS	__YES	__NO	TUMORS	__YES	__NO
ALCOHOLISM	__YES	__NO	FRACTURES	__YES	__NO	OSTEOPOROSIS	__YES	__NO	TYPHOID		
ALLERGY SHOTS	__YES	__NO	GLAUCOMA	__YES	__NO	PACEMAKER	__YES	__NO	FEVER	__YES	__NO
ANEMIA	__YES	__NO	GOITER	__YES	__NO	PARKINSON'S DISEASE	__YES	__NO	ULCERS		
ANOREXIA	__YES	__NO	GONORRHEA	__YES	__NO	PINCHED NERVE	__YES	__NO	VAGINAL	__YES	__NO
APPENDICITIS	__YES	__NO	GOUT	__YES	__NO	PNEUMONIA	__YES	__NO	INFEC.		
ARTHRITIS	__YES	__NO	HEART DISEASE	__YES	__NO	POLIO	__YES	__NO	VENEREAL		
ASTHMA	__YES	__NO	HEPITITIS	__YES	__NO	PROSTATE PROBLEM	__YES	__NO	DISEASE	__YES	__NO
BLEEDING DISORDER	__YES	__NO	HERNIATED DISK	__YES	__NO	PROSTHESIS	__YES	__NO	WHOOPING		
BREST LUMP	__YES	__NO	HERPES	__YES	__NO	PSYCHIATRIC CARE	__YES	__NO	COUGH	__YES	__NO
BRONCHITIS	__YES	__NO	HIGH CHOLESTEROL	__YES	__NO	RHEUMATOID ARTHRITIS	__YES	__NO	OTHER: _____		
BULIMIA	__YES	__NO	KIDNEY DISEASE	__YES	__NO	RHEUMATIC FEVER	__YES	__NO	_____		
CANCER	__YES	__NO	LIVER DISEASE	__YES	__NO	SCARLET FEVER	__YES	__NO	_____		
CATARACTS	__YES	__NO	MEASLES	__YES	__NO	STROKE	__YES	__NO	_____		
CHEMICAL DEPENDENCY	__YES	__NO	MIGRAINE HEADACHES	__YES	__NO	SUICIDE ATTEMPT	__YES	__NO	_____		
CHICKEN POX	__YES	__NO	MISCARRIAGE	__YES	__NO	THYROID PROBLEMS	__YES	__NO	_____		
DIABETES	__YES	__NO	MONONCLEOISIS	__YES	__NO	TONSILLITIS	__YES	__NO	_____		
EMPHYSEMA	__YES	__NO	MULTIPLE SCLEROSIS	__YES	__NO	TUBERCULOSIS	__YES	__NO	_____		

EXERCISE:	WORK ACTIVITY:	HABITS:	
__ NONE	__ SITTING	__ SMOKING	PACKS/DAY_____
__MODERATE	__ STANDING	__ ALCOHOL	DRINKS/WEEK _____
__DAILY	__ LIGHT LABOR	__ COFFEE/CAFFENINE DRINKS	CUPS/DAY _____
__HEAVY	__ HEAVY LABOR	__ HIGH STRESS LEVEL	REASON(S)_____

ARE YOU PREGNANT? __ YES __ NO DUE DATE: _____

INJURIES/SURGURIES YOU HAVE HAD:	DESCRIPTION:	DATE:
FALLS	_____	_____
HEAD INJURIES	_____	_____
DISLOCATIONS	_____	_____
SURGERIES	_____	_____

7 MEDICATIONS: ALLERGIES: VITAMINS/HERBS/MINERALS:

MEDICATIONS:	ALLERGIES:	VITAMINS/HERBS/MINERALS:
_____	_____	_____
_____	_____	_____
PHARMACY NAME:_____	_____	_____
PHARMACY PHONE:_____	_____	_____

Gray Chiropractic Health Clinic

360 E. International Airport Road, Suite 4

Anchorage, Ak 99518

CONSENT TO TREAT

To Our Patients:

Chiropractic examination and therapeutic procedures including but not limited to spinal adjustments, ultrasound, heat /ice application, electrotherapy, and manual muscle therapy are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature:_____

Date:_____

CONSENT FOR X-RAYS

I agree to allow x-rays to be taken during any of my appointments if deemed medically necessary. By signing below I am stating that I am not pregnant and agree to inform the doctor if at any time during my treatment I may be pregnant.

Signature:_____

Date of last menstrual cycle (if applicable):_____

Date:_____