

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

Occupation: _____ **Employer:** _____

Date of Birth: _____ **SS#:** _____

Emergency contact: _____ **Phone:** _____

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 _____

Confidential Health History

Chiropractor's Notes

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
 Other: _____

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? _____

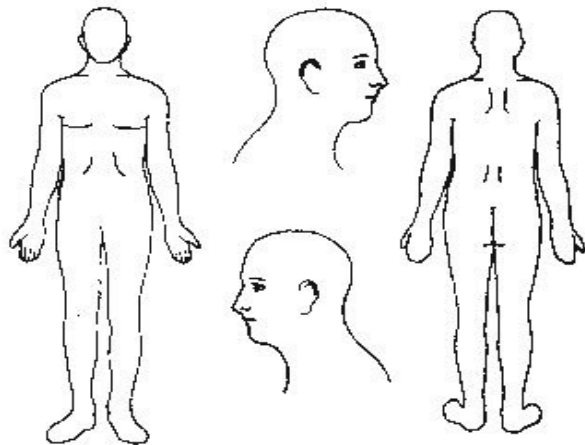
How frequent is this condition? Constant "Comes and Goes"
 Daily Night Only Other: _____

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

What makes it worse? Sitting Standing Walking Bending
 Lifting Sleeping Sneezing/Coughing Reaching Twisting
 Looking Up or Down Laying Driving Movement
 Typing Housework Exercise 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? _____

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. Have you ever experienced problems in the following systems?

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

Primary Physician's Name: _____ Phone: _____

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

Past Personal History. Please identify your past health history.

Have you ever had any of the following problems?

- Allergies/Food Sensitivities Arthritis Cancer Diabetes
 Frequent Constipation Frequent Headaches Heart Disease
 Hypertension Osteopenia/Osteoporosis Stroke

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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Family History: Are there problems that run in your family?

Mom: Cancer Diabetes High Blood Pressure Other: _____

Dad: Cancer Diabetes High Blood Pressure Other: _____

Siblings: Cancer Diabetes High Blood Pressure Other: _____

Social History:

Alcohol use : Daily Weekly Soft Drinks: Daily Weekly

Tobacco use: Daily Weekly Coffee: Daily Weekly

Pain Relievers: Daily Weekly Water intake: Glasses Daily ____

Exercise: None Daily Weekly Moderate Heavy

Stress Level: Low Moderate High

Sleep: Back Side Stomach Average hours per night? ____

Work Activity: Sitting Standing Light Labor Heavy Labor

Name
DOB
DC Initials
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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Driving/Traveling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Recreation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising from Chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Social Life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housework	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Duties at work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 misrepresented the presence, severity or cause of my health concern.

Signature: _____ **Date:** _____

Office Use: Name _____ DOB _____ Initials _____

We are required to ask you the following questions:

Marital Status (check one) Single Married Other

Employment Status (check one) Employed Student Retired Self Employed Other

Race (check one) I choose not to specify White African-American Hispanic
 Asian Other _____ Multi-Racial

Preferred Language (check one) I choose not to specify English Spanish French
 Other _____

If you request a copy of your health records, we can give them to you in person or email them.

Email: _____

By providing my email address, I authorize my chiropractor to send health records to the email address provided.

Please choose one Verification Question to help us protect your privacy.

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
 What is your favorite movie? What is your mother's maiden name?
 On what street did you grow up? What was the make of your first car? When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? Yes Former smoker Never a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

0 1 2 3 4 5 6 7 8 9 10

No interest

Very Interest

Do you have allergies to any medications? If none, check here:

Has any doctor diagnosed you with Hypertension presently? Yes No

Has any doctor diagnosed you with Diabetes presently? Yes No

If yes, what kind? Type I Type II

If yes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?
 Yes No

If known, please provide the following:

Height: _____ inches **Weight:** _____ pounds **Blood Pressure:** ____ / ____

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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.

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 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 or use it for marketing products.

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

Patient Signature

Date