Consultation Forms

Graham Chiropractic

First Last Middle Init.

Address City St Zip

Cell Home Work

DOB: Email Status S M D W

SSN# How where you referred

Chief Complaint

Date it Started Cause

If an injury, where did it happen?

All past surgeries:

History of cancer:

History of organic problems (liver, heart, etc.)

Other History (prior hospitalization):

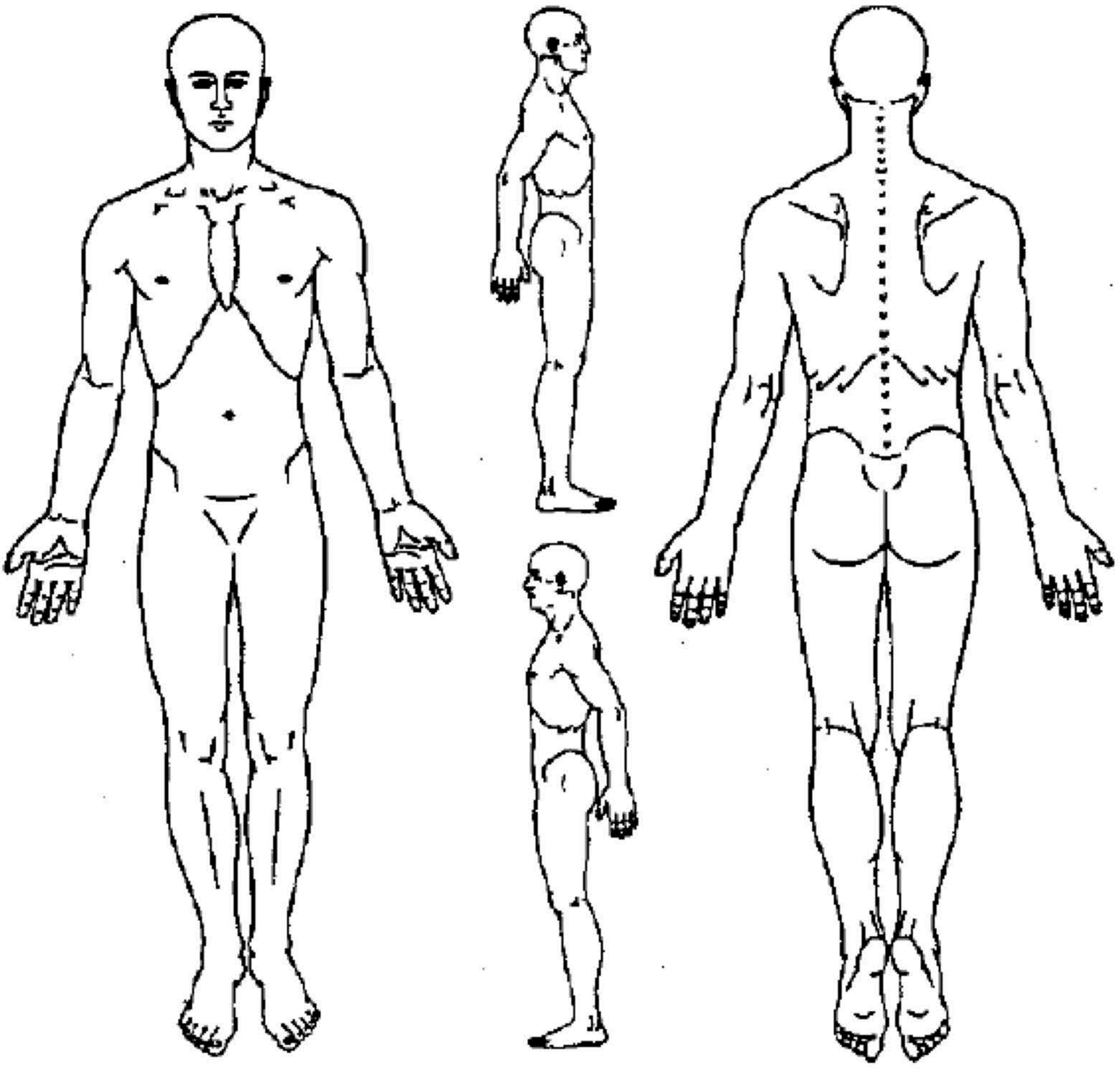
Medications:

Females: ARE you Pregnant? YES NO

Patient's Sig.: Date:

Pain Diagram

Please mark the area of injury or discomfort on the chart below:



Please use the space below to describe your condition further if needed:

Signature_____ Date:_____

Low back pain-Circle all that apply

Location of pain	Right Side	Left Side	Central
Radiation into Leg YES NO	R- side: Gluteal Thigh front side back Calf front side back Ankle Foot top bottom Toes inner outer L- side: Gluteal Thigh front side back Calf front side back Ankle Foot top bottom Toes inner outer		
When did pain start? Cause of pain	_____YRS _____months ago _____days Unknown Other Please explain:		
Palliative Measures:	**OTC**: Aleve Advil Tylenol **Heat** **Ice** **Creams** **Massage** **Stretches** **Exercises** **Prescription:** Pain pills Muscle relaxers Anti-inflammatories Steroid shots Other:		
Provokes the pain	**Sitting** for _____ minutes **Standing** ___ min **Walking** ____min **Sitting to standing** Bending Lifting Twisting Coughing /Sneezing Laying down Other:		
Quality of pain	Dull Achy Sharp Burning Other		
Setting	Worse in the: Morning Afternoon Evening With Activity		
Timing	Feel the pain: Some of the Time Most of the Time All the time feel some sort of pain		

Neck pain-Circle all that apply

Location of pain	Right Side	Left Side	Central
Radiation into arm YES NO	R- side: shoulder arm inner outer forearm wrist hand fingers inner outer R- side: shoulder arm inner outer forearm wrist hand fingers inner outer		
When did pain start? Cause of pain	_____YRS _____months ago _____days Unknown Other Please explain:		
Palliative Measures:	**OTC**: Aleve Advil Tylenol **Heat** **Ice** **Creams** **Massage** **Stretches** **Exercises** **Prescription:** Pain pills Muscle relaxers Anti-inflammatories Steroid shots Other:		
Provokes the pain	**Looking up** **Looking down** **Turning right** **Turning left** **Driving** **Coughing /Sneezing** **Other:**		
Quality of pain	Dull Achy Sharp Burning Other		
Setting	Worse in the: Morning Afternoon Evening With Activity		
Timing	Feel the pain: Some of the Time Most of the Time All the time feel some sort of pain		

Mid back pain-Circle all that apply

Location of pain	Right Side	Left Side	Central
When did pain start? Cause of pain	_____YRS _____months ago _____days Unknown Other Please explain:		
Palliative Measures:	**OTC**: Aleve Advil Tylenol **Heat** **Ice** **Creams** **Massage** **Stretches** **Exercises** **Prescription:** Pain pills Muscle relaxers Anti-inflammatories Steroid shots Other:		
Provokes the pain	**Sitting** for _____ minutes **Standing** ___ min **Walking** ____min **Sitting to standing** Bending Lifting Twisting Coughing /Sneezing Laying down Other:		
Quality of pain	Dull	Achy	Sharp Burning Other
Setting	Worse in the: Morning	Afternoon	Evening With Activity
Timing	Feel the pain: Some of the Time	Most of the Time	All the time feel some sort of pain

Low Back

1. PAIN INTENSITY
- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING
- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

SCORE:_____

Name: _____ Date: _____

Signature: _____ Date: _____

Consent for Chiropractic Care

I hereby request that Stephen Graham, D.C. provide chiropractic services for me (or my minor child whose name appears below). I understand that care is to be provided by Stephen Graham, D.C. or his designated assistant. Stephen Graham, D.C. has discussed care with me, and I understand that:

1. The purpose of chiropractic care is to contribute to health by the location analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.

2. Chiropractic is a separate and distinct profession, and is not the practice of medicine; therefore, diagnosis and medical conditions is not a primary goal, however, I will be informed of abnormal findings.

3. Chiropractors do not give medical advice, nor do they discourage me from receiving medical advice. If deemed advisable, Stephen Graham, D.C. will refer me for medical services with all possible diligence.

4. Stephen Graham, D.C. uses only chiropractic methods that are taught in accredited colleges and appropriate techniques will be selected for my spinal care based upon standard professional protocols.

5. Chiropractic adjustments are exceedingly safe when applied properly; however, all actions in life come with some risk, including chiropractic adjustments.

6. Although the risks are very minimal, there have been rare reports of vertebral artery damage., fractures and aggravation of disc conditions associated with chiropractic procedures.

7. That because a small force is introduced into the spine during an adjustment, there may be temporary minor musculoskeletal discomfort.

8 That I am an active participant in my chiropractic care, and I am there invited to ask any questions or express any concerns that i may have.

9. That I am free to withdraw my consent and discontinue care at any time.

Name _____ *Date*_____

Parent/Guardian (if minor) _____ *Date*_____

Re: Medical Reports and Doctor's Lien

I do hereby authorize Graham Chiroprac tic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct your my attorney, to pay directly to Stephen Graham such sums as may be due and owing him for medical service rendered me bothy reason of this accident and by reason of any bills that are due to his office and withhold such sums from any settlement, judgement or verdict as may be necessary to adequeatley protect Stephen Graham. And I hereby further give a lien on my case to Dr. Stephen Graham against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection with.

I fully understand that I am directly and fully responsible to Dr. Stephen Graham for all medical bills submitted by him for services rendered to me and that this agreement is is made solely for Stephen Graham's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient's Signature: _____Date:_____

I understand being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Dr. Stephen Graham.

Date: _____

Attorney's Signature: _____

A faxed copy will serve as the original

CHIROPRACTIC Consent for Use or Disclosure of Protected Health Information for the Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to Graham Chiropractic using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out GrahamChiropractic's healthcare operations. I also consent to Graham Chiropractic using or disclosing my protecied health information for treatment activities provided by another healthcare provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing competence of healthcare professionals.

I hereby authorize Graham Chiropractic to perform an examination and any other medical services deemed necessary. I assume full financial responsibility for all charges by Graham Chiropractic, even if my insurance
does not cover these services. I authorize the appropriate office personnel to submit insurance claims on my behalf and for any insurance proceeds paid on my behalf to be paid directly to Graham Chiropractic. I authorize the release of any medical information required by my insurance carrier for services f urnished to me by GrahamChiropractic.

I acknowledge Graham Chiropractic has provided me a copy of its Notice of Privacy Practices, which provides a
detailed description of the uses and disclosures allowed by this Consent, as well as other rights I have regarding
my protected health information.

I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- I acknowledge I had the opportunity to review the Notice of Privacy Practices.
- Graham Chiropractic reserves the right to change the Notice of Privacy Practices.
- I have the right to restrict the uses of my information but Graham Chiropractic does not have to agree
  to those restrictions.
- I may revoke this Consent in writing at any time and all future disclosures will then cease.
- Graham Chiropractic may condition treatment upon the execution or revocation of this Consent.
- Information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient
  and may no longer be protected by federal or state law.

Printed Name of Patient

Patient Social Security Number

Signature of Patient or Personal Representative

Patient Date of Birth

Description of Personal Representative's Authority

Date

HIPAA AND OUR PATIENTS

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA*) and accompanying regulations controls the use and disclosure of what is known as protected health information (PHI). Implementation of and compliance with HIPAA is not an option for Graham Chiropractic.

Please read and familiarize yourself with the attached material. It is your copy so feel free to take it with you. Sign the Acknowledgment Form indicating that you have received a copy. It will be a permanent part of your medical record. If you are a parent or personal representative of a patient, we will need an Acknowledgment Form signed by you on behalf of the patient.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge Graham Chiropractic has provided me with a copy of its Notice of Privacy Practices,which contains a detailed description of the uses and disclosures allowed by this Privacy Notice, as well as the rights I have regarding my protected health information.

_____ _____

Printed Name of Patient Patient Social Security Number

_____ _____

Signature of Patient or Personal Representative Patient Date of Birth

_____ _____

Description of Personal Representative's Authority Date

_____

Date

(HIPPA)

For Insurance Recipients Only

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand Graham Chiropractic will file claims to my insurance carrier as a courtesy and will prepare any necessary reports and forms to assist in making collections from the insurance carrier. However, I clearly understand and agree that all services rendered me and charged directly to me and that I am personally responsible for payment.

I authorize the release of any medical and or other information necessary to process the claim. I also request payment of benefits paid directly to Graham Chiropractic and credited to my account upon receipt.

Patients Signature _____

Date _____

For Medicare Recipients Only

Medicare will only pay for services to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment of that service. Coverage for chiropractic services is specifically limited to treatment by means of spinal manipulation.
However, our office required x-rays and/or other diagnostic tests for the purpose of determining or demonstrating the existence of a subluxation of the spine and I believe that these services will be denied. Medicare does case by case review; as to the number of visits they will cover.

I understand that Graham Chiropractic will file my claims and provide any required reports of forms.

Patients Signature _____

Date _____