



HONEST
SPINE HEALTH

PATIENT INFORMATION

Name _____
Email Address _____
Address _____
City _____ State _____ Zip _____
Date of Birth ____ / ____ / ____ Sex: M F
Marital Status: S M D W Minor
Occupation: _____
Employer/School: _____
How did you hear about us? _____

PHONE NUMBERS

Home Phone: (____) _____-_____
Cell Phone: (____) _____-_____
EMERGENCY CONTACT
Name: _____
Relationship: _____
Phone: (____) _____-_____

INSURANCE INFORMATION

Do you have health insurance? Y N
Name of carrier: _____
Do you have secondary insurance? Y N
If yes, name of carrier: _____

Agreement and Release

I certify that I and/or my dependent(s) have insurance coverage with the above named company and AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE; Dr. Vincent Gross/Honest Spine Health, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. 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, including the diagnosis and records or any exam or treatment rendered to me, in order to secure payment of benefits. I authorize the use of this signature claims, including electronic submissions.

Signature _____ Date _____

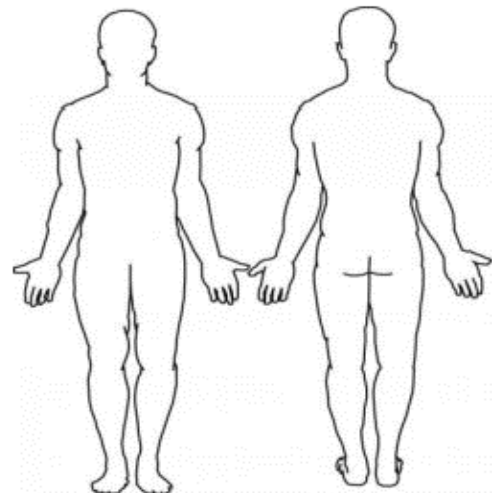
ACCIDENT INFORMATION

Is this condition due to an accident? Y N
If YES:
Date _____ Type of Accident:
Auto Work Other _____

PATIENT CONDITION

Reason for visit: _____
When did the symptoms appear? _____
Is the condition getting progressively worse?
 YES NO UNSURE
Type of pain (check all that apply):
 Sharp Dull Throbbing Numbness
 Burning Tingling Cramps Stiffness
 Swelling Shooting Aching Other (please explain) _____
How often do you have the pain? _____
Is it constant or does it come and go? _____
Does anything make it better? _____
Does anything make it worse? _____

Mark the areas of pain on the figures below.



HEALTH HISTORY

What, if any, treatment have you already received for your condition? Medication Surgery Physical Therapy Chiropractic Services None Other _____
 Date of Last: Spinal X-Ray _____ MRI _____ EMG _____

Check to indicate if you are CURRENTLY experiencing any of the following conditions

- | | |
|--|--|
| <input type="checkbox"/> neck pain
<input type="checkbox"/> back pain
<input type="checkbox"/> arm/hand pain
<input type="checkbox"/> leg/knee pain
<input type="checkbox"/> headaches
<input type="checkbox"/> dizziness
<input type="checkbox"/> blurred vision
<input type="checkbox"/> pins/needles in arm
<input type="checkbox"/> pins/needles in legs
<input type="checkbox"/> Fatigue
<input type="checkbox"/> sleeping difficulties
<input type="checkbox"/> loss of smell
<input type="checkbox"/> allergies
<input type="checkbox"/> night pain
<input type="checkbox"/> light bothers eyes | <input type="checkbox"/> Bowel/ bladder changes <input type="checkbox"/> sudden weight loss
<input type="checkbox"/> loss of taste
<input type="checkbox"/> loss of memory
<input type="checkbox"/> jaw problems
<input type="checkbox"/> constipation
<input type="checkbox"/> shortness of breath
<input type="checkbox"/> nausea
<input type="checkbox"/> cold feet
<input type="checkbox"/> chest pain
<input type="checkbox"/> fever
<input type="checkbox"/> fainting
<input type="checkbox"/> asthma
<input type="checkbox"/> tension
<input type="checkbox"/> nervousness
<input type="checkbox"/> cold sweats
<input type="checkbox"/> stomach problems
<input type="checkbox"/> depression |
|--|--|

Check to indicate if you have EVER had any of the following

- | | |
|--|---|
| <input type="checkbox"/> Aids/HIV
<input type="checkbox"/> alcoholism
<input type="checkbox"/> allergy shots
<input type="checkbox"/> anemia
<input type="checkbox"/> anorexia
<input type="checkbox"/> appendicitis
<input type="checkbox"/> arthritis
<input type="checkbox"/> bleeding disorders
<input type="checkbox"/> breast lump
<input type="checkbox"/> bronchitis
<input type="checkbox"/> bulimia
<input type="checkbox"/> cancer
<input type="checkbox"/> cataracts
<input type="checkbox"/> chemical dependency
<input type="checkbox"/> chicken pox
<input type="checkbox"/> diabetes
<input type="checkbox"/> emphysema
<input type="checkbox"/> glaucoma
<input type="checkbox"/> goiter
<input type="checkbox"/> gout
<input type="checkbox"/> heart disease
<input type="checkbox"/> hepatitis
<input type="checkbox"/> hernia
<input type="checkbox"/> herniated disc
<input type="checkbox"/> herpes
<input type="checkbox"/> high blood pressure
<input type="checkbox"/> high cholesterol | <input type="checkbox"/> kidney disease
<input type="checkbox"/> liver disease
<input type="checkbox"/> migraines
<input type="checkbox"/> miscarriages
<input type="checkbox"/> multiple sclerosis <input type="checkbox"/> mumps
<input type="checkbox"/> osteoporosis
<input type="checkbox"/> pacemaker
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> pinched nerve
<input type="checkbox"/> pneumonia
<input type="checkbox"/> polio
<input type="checkbox"/> prostate problems
<input type="checkbox"/> prosthesis
<input type="checkbox"/> psychiatric care
<input type="checkbox"/> rheumatoid arthritis
<input type="checkbox"/> rheumatic fever
<input type="checkbox"/> scarlet fever
<input type="checkbox"/> stroke
<input type="checkbox"/> suicide attempt
<input type="checkbox"/> thyroid problems
<input type="checkbox"/> tonsillitis
<input type="checkbox"/> tuberculosis
<input type="checkbox"/> tumors/growths
<input type="checkbox"/> typhoid fever
<input type="checkbox"/> ulcer
<input type="checkbox"/> vaginal infections
<input type="checkbox"/> venereal disease
<input type="checkbox"/> whooping cough
<input type="checkbox"/> OTHER |
|--|---|

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

ALLERGIES

Injuries/Surgeries (date)

Falls _____
 Head injury _____
 Dislocations _____
 Surgeries _____

 Other _____

MEDICATIONS

What is your daily/weekly intake of the following?

- smoking packs/day _____
 alcohol drinks/week _____
 coffee/ caffeine drinks cups/day _____

Family History Please indicate if anyone in your family has ever had any of the following:

- Cancer Heart Disease Diabetes
 Arthritis _____
 Other _____

I certify that the information I have provided is accurate. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE _____ Date _____

Informed Consent
Chiropractic Care
Vincent Gross, D.C.
DC007869L

Patient's Name: _____ Date of Care Plan ___/___/___

**Instructions: This document relates to your informed consent for care.
Please read carefully before signing.**

General: I, the below-signed patient/individuals, have read this document in its entirety and understand that potential benefits and risks of the care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under the state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider is listed above.

I do not expect to be able to anticipate and explain all risks and complications, or forms of treatment and I wish to rely on you to exercise judgment within your scope of practice during the course of the care plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities, or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the care whether I am suffering for any latent pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care: Alternatives

Chiropractic manipulation/adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fracture, disk injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are a rare occurrence and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "RARE."

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxers and pain killers; hospitalization with tractions; and surgery.

Contraindications to Manipulation/Adjustment

I understand that you will not give me an adjustment/manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions

"You" and "office" refer to any provider who renders care to me at the location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other condition.

Patient's Consent

I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my conditions, and also all the information in this informed consent. I have had ample opportunity to explore other potential forms of care, have asked you all the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: _____

Patient's Signature: _____ Date: ___/___/___

Name of parent/guardian/authorized representative: _____

Signature: _____ Date: ___/___/___

Patient Consent

Regarding the Use & Disclosure of Protected Health Information

For the purpose of this consent form, "office" shall refer to: Honest Chiropractic

I understand that some of my health information may be used and/or disclosed by the office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy at any time prior to signing this form.

I understand that over time the office's privacy practices may need to change in accordance with the law and that if I wish to obtain a copy of the revised notice, I can call the office to request a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent, but only to the extent that the office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be in writing.

Patient Name _____

Signature _____ Date: ____ / ____ / ____