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)

_____

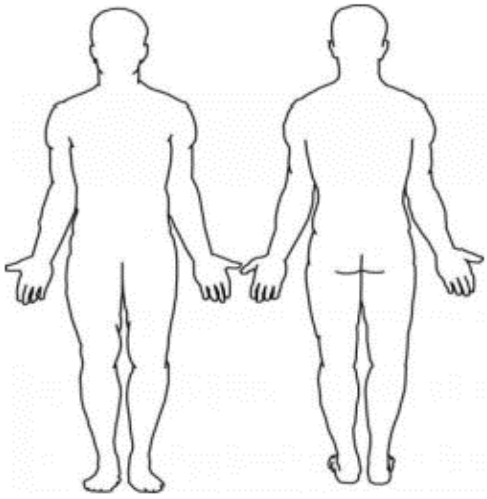
How often do you have the pain?_____

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

□ neck pain
□ back pain
□ arm/hand pain
□ leg/knee pain
□ headaches
□ dizziness
□ blurred vision
□ pins/needles in arm
□ pins/needles in legs
□ Fatigue
□ sleeping difficulties
□ loss of smell
□ allergies
□ night pain
□ light bothers eyes

□ Bowel/ bladder changes □ sudden weight loss
□ loss of taste
□ loss of memory
□ jaw problems
□ constipation
□ shortness of breath
□ nausea
□ cold feet
□ chest pain
□ fever
□ fainting
□ asthma
□ tension
□ nervousness
□ cold sweats
□ stomach problems
□ depression

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

□ **Aids/HIV**
□ **alcoholism**
□ **allergy shots**
□ **anemia**
□ **anorexia**
□ **appendicitis**
□ **arthritis**
□ **bleeding disorders**
□ **breast lump**
□ **bronchitis**
□ **bulimia**
□ **cancer**
□ **cataracts**
□ **chemical dependency**
□ **chicken pox**
□ **diabetes**
□ **emphysema**
□ **glaucoma**
□ **goiter**
□ **gout**
□ **heart disease**
□ **hepatitis**
□ **hernia**
□ **herniated disc**
□ **herpes**
□ **high blood pressure**
□ **high cholesterol**

□ kidney disease
□ liver disease
□ migraines
□ miscarriages
□ multiple sclerosis □ mumps
□ osteoporosis
□ pacemaker
□ Parkinson's disease
□ pinched nerve
□ pneumonia
□ polio
□ prostate problems
□ prosthesis
□ psychiatric care
□ rheumatoid arthritis
□ rheumatic fever
□ scarlet fever
□ stroke
□ suicide attempt
□ thyroid problems
□ tonsillitis
□ tuberculosis
□ tumors/growths
□ typhoid fever
□ ulcer
□ vaginal infections
□ venereal disease
□ whooping cough
□ 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_____

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

SIGNATURE_____ **Date**_____

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

□ **Cancer** □ **Heart Disease** □ **Diabetes**
□ **Arthritis**_____
□ **Other**_____

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 you 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 fell 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:** ____/____/____