# GRIFFIN FAMILY WELLNESS

## 1 GENERAL INFORMATION

Date: _____

Name: _____
Last Name First Name Initial

Address: _____

_____

Home Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Sex: □ M □ F Birth date: _____

□ Single □ Married □ Divorced □ Widowed

Social Security #: _____

Occupation: _____

Employer: _____

Employer Phone #: _____

*IN CASE OF AN EMERGENCY, CONTACT*

Name:_____ Relation: _____

Phone #:_____

**How did you hear about us?** _____

## 2 INSURANCE INFORMATION

**Health Insurance** *(Primary)*

Ins Co.: _____ Phone:_____

Policyholder name:_____

Relationship to policyholder:_____

Policy #: _____ Group#:_____

**Health Insurance** *(Secondary)*

Ins Co.: _____ Phone:_____

Policyholder name:_____

Relationship to policyholder:_____

Policy #: _____ Group#:_____

## 3 ACCIDENT INFORMATION *(IF APPLICABLE)*

Did this injury occur at work (Worker's Compensation)? (circle) YES NO

Did this injury occur as a result of a car accident, fall or other personal injury? YES NO

Date of Injury:_____ Time:_____ AM/PM

Claim #_____Adjustors Name:_____

Insurance Company:_____Address:_____

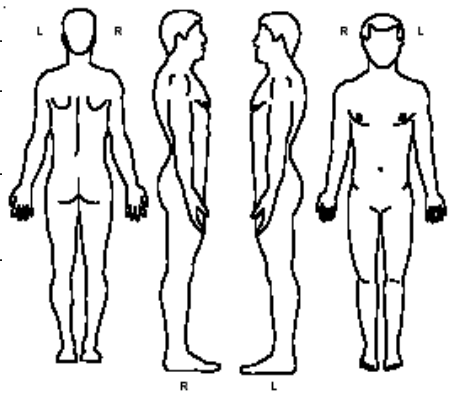
City: State: Zip: Office phone

## 4 COMPLAINTS

What are your present complaints? *(Location of pain, etc.)*_____

_____

Use an "X" on the drawing to mark where you are experiencing pain *(or other symptoms)*.




When did these symptoms first appear? _____

Are you working less hours / days as a result of your injuries? □ Yes □ No

If yes, please explain _____

Activities or movements that are painful to perform:

□ Sitting □ Standing □Walking □ Bending □ Lying Down

How would you rate your symptoms: □ Mild □ Moderate □ Severe

How would you rate your current symptoms (pain): □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

No Symptoms Worst Possible

## 5 EXAMINATION HISTORY

Have you been to the hospital for *this* condition? □ Yes □ No If yes, name of hospital? _____

When did you go? _____ How did you get there? □ Ambulance □ Self □ Others

Were x-rays taken? □ Yes □ No If yes, what area(s)? _____

Were you prescribed any medication? □ Yes □ No If yes, what medications? _____

Have you seen any other doctor or received any other treatment for your current condition? □ Yes □ No

If yes, explain _____

Doctor's name and address: _____

Phone #: _____ Date(s) seen: _____ Diagnosis: _____

## 6 HEALTH HISTORY / INJURIES / TREATMENTS

**INJURIES YOU MAY HAVE HAD IN THE PAST** Description

_____ _____

**HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM:** ***(place "X" in boxes that apply)***

| | | | |
|---|---|---|---|
| □ Muscle disorder | □ Lungs, Asthma | □ Osteoarthritis | □ Neck pain/stiffness R L |
| □ Broken Bones | □ Epilepsy | □ Trouble sleeping | |
| □ Bone Disorder | □ Headaches | | |
| □ Rheumatoid Arthritis | □ Pace Maker | □ Hip pain R L | |
| □ Allergies | □ Seizures/Convulsions` | □ Strokes | □ Numbness, tingling, pain in arms, hands, fingers R L |
| □ Dizziness | □ Diabetes | □ High Blood Pressure | □ Upper Back Pain/Stiffness |
| □ Depression | □ Low Blood Pressure | □ Low Back Pain/Stiffness | |
| □ Kidney, Bladder (GU) | □ Tumors | □ Mid Back Pain/Stiffness | |

**SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION:** Date (s)

Spine Surgeries □ Discectomy □ Laminectomy □ Fusion □ Other:_____ _____

**NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION:** ***(place "X" in boxes that apply)***

| | | |
|---|---|---|
| □ Medication *(OTC / Prescription)* | □ Injections | □ Physical Therapy *(Dates:_____)* |
| □ Massage | □ Chiropractic | □ Acupuncture |

□ Other: _____

## Griffin Family Wellness Consent To Services

**CONSENT TO CHIROPRACTIC &/OR PHYSICAL THERAPY SERVICES** Pt. Initials_____

I hereby request and consent to comprehensive examinations (chiropractic &/or physical therapy orthopedic &/or neurological), chiropractic adjustments/treatments (and other procedures including various modes of physiotherapy modalities), physical therapy intervention (including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program), nutritional counseling/advice by GFW (& it's staff), who now or in the future treat me. I have had an opportunity to discuss the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgment during the course of any procedure which the doctor(s) feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by GFW and/or employed staff.

**CONSENT TO TREATMENT OF A MINOR** CHILD (Under the age of 18) Pt. Initials_____

I authorize Chiropractic &/or Physical Therapy care as deemed necessary to my (relationship)_____.

**PATIENT'S RIGHTS** Pt. Initials_____

Griffin Family Wellness (GFW) respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

**PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME** Pt. Initials_____

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum in now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for products or professional services rendered will be immediately due and payable.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

PRINTED_____ SIGNED_____ DATE_____