Dr. Lawrence S. Grimm, D.C., A.R.T.
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Case History/Patient Information

Date:_____ Patient Name:_____

Address:_____City:_____**State**:_____**Zip:**_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Would you like to receive appointment reminders via text messaging? □ Yes □ No

E-mail address: _____ Appointment reminders by e-mail? □ Yes □ No

Gender: _____ **Birthdate:** _____ **Marital Status:** M S W D

Employment Status: _____ **SSN:** _____ - _____-_____

Employer Name: _____ **Occupation:** _____

Guardian (for minors)**: Name:**_____ **Relation:** _____ **Phone:** _____

Emergency Contact: **Name:**_____ **Relation:** _____ **Phone:** _____

How were you referred to our office? _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.
The patient understands and agrees to allow Premier Sports Chiropractic to use their Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patients Signature:_____ **Date:**_____

Guardian's Signature Authorizing Care: _____ **Date:**_____

History of Present Illness:

What is your major symptom? _____

Date symptoms appeared or accident happened: _____

Is this due to: □Auto □Work □Other **_____ Days lost from work: _____**

What does this prevent you from doing or enjoying? _____

Is this a recurrence? □Yes □ No

If yes, when was the first time you noticed this problem and how did it originally occur? _____

_____

Has it become worse recently? □Yes □ No □ Same □ Better □ Gradually Worse

If yes, when and how? _____

How frequent is the condition? □ Constant through out the day □ Comes and goes during the day

□ Only present with movement or activity

How long does it last? □ All Day □ Few Hours □ Minutes

Are there any other conditions or symptoms that may be related to your major symptom? □Yes □ No

If yes, describe: _____

Are there other unrelated health problems? □Yes □ No If yes, describe: _____

_____

Describe the pain: □ Dull □ Achy □ Sharp □ Shooting □ Numbness □ Tingling □ Burning

□ Tightness □ Other _____

Is there anything you can do to relieve the problem? □Yes □ No If yes, describe. If no, what have you tried that has not helped? _____

What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting

□ Other _____

List any major accidents you have had other than those that might be mentioned above:

_____

On the line below, please indicate your current level of pain/discomfort

No pain **0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10** Emergency Room

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

□Yes □ No □ Uncertain

Past Medical History:

Have you ever been diagnosed or having suffered from:

□ Broken or fractured bones	□ Osteoarthritis	□ Eating disorder	□ Alcoholism
□ Circulatory Problems	□ Rheumatoid Arthritis	□ Pacemaker	□ Epilepsy
□ Drug Addiction	□ Seizures/Convulsions	□ Strokes	□ HIV Positive
□ A Congenital Disease	□ Cancer	□ Gall Bladder	□ Ulcers
□ Excessive Bleeding	□ Coughing Blood	□ Depression	□ Ruptures
□ High/Low Blood Pressure			

Do you have a history of stroke or hypertension? □Yes □ No

Have you had any major injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

_____

Have you been treated for a health condition by a physician in the last year? □Yes □ No

If yes, describe: _____

What medications or drugs are you taking? _____

_____

Medication Allergies: □Yes □ No

If yes, list and describe: _____

Do you have allergies of any kind? □Yes □ No

If yes, list and describe: _____

Please list any other health problems you have, no matter how insignificant they may seem:

_____

_____

Social History:

Do you drink alcoholic beverages? □Yes □ No If yes, how much per week? _____

Do you use any tobacco products? □Yes □ No If yes, how often? _____

Do you take vitamin supplements? □Yes □ No If yes, please list: _____

Do you consume caffeine? □Yes □ No If yes, how much per day? _____

Do you exercise? □Yes □ No If yes, frequency and form of exercise: _____

What are your hobbies? _____

Family History:

□ Adopted as child, little is known of birth parents or family.

Father: □ Living □ Deceased

Current age if living: _____

Cause of death & age at death if deceased:

_____

Mother: □ Living □ Deceased

Current age if living: _____

Cause of death & age at death if deceased:

_____

Do you have any family members who suffer from the same condition you do? □Yes □ No

If yes, please list: _____

Family Diseases (circle whether family member is **F**ather, **M**other, **S**ister, or **B**rother):

□ Tuberculosis **F M S B**
□ Cancer **F M S B**
□ Mental Illness **F M S B**
□ Diabetes **F M S B**
□ Asthma **F M S B**
□ Kidney Disease **F M S B**
□ Heart Disease **F M S B**
□ Stroke **F M S B**
□ Lung Disease **F M S B**
□ Liver Disease **F M S B**
□ Arthritis **F M S B**
□ Other _____

PREMIER SPORTS CHIROPRACTIC

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INFORMED CONSENT

PATIENT NAME _____

The primary treatment used by Doctors of Chiropractic is the spinal manipulation, sometimes called spinal adjustment.

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc 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.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- **Ancillary treatment.**
  In addition to chiropractic adjustments, I intend to use the following treatments:

  _____

  _____

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:

  - Self-administered, over-the-counter analgesics and rest
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
  - Hospitalization with traction
  - Surgery

The material risks inherent in such options and the probability of such risks occurring include:

- Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

- Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.

- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

- The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mis- hap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

- **The risks and dangers attendant to remaining untreated.**
  Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the treating doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Printed Name: _____

Date: _____

Signature: _____

Guardian (if minor): _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Patient and/or Guardian of Patient Date