INITIAL HEALTH STATUS

PERSONAL & CONFIDENTIAL

Please Tell us About Yourself...

Your Name:____
Address:____
City:_______________________ **State**:__________ **Zip**:________________
Primary Phone: H W C ( ) ______________________________
Second Phone: H W C ( ) ______________________________
Your Email:____
Primary Physician:____
Primary Physician Phone: ( ) ____________________________
Sex: M / F **Age**:________ **Birthdate**:_______________________
Social Security:__________________ **Driver's Lic.**:________________
Marital Status: S / M / D / W **# of Children**:_______________
Spouse's Name:____
Spouse's Employer:_______________________________________
How Were You Referred to Our office?______________________

Please Describe Your Current Problem

What Brings You to Our Office Today? (circle one)

Flare-up Recent Trauma Auto Related Work Related

O Headache O Neck Pain O Mid Back Pain O Low Back Pain

Other Area(s) of Complaint:________________________________
____
When Did Your Problem Begin?:______________________________
How Did Your Problem Begin?:_______________________________
____

Current Primary Complaint *(How do You Feel Today?)*

0 1 2 3 4 5 6 7 8 9 10

No Pain *(circle one)* *Unbearable Pain*

Of Your Day, How Often Are Your Symptoms Present?

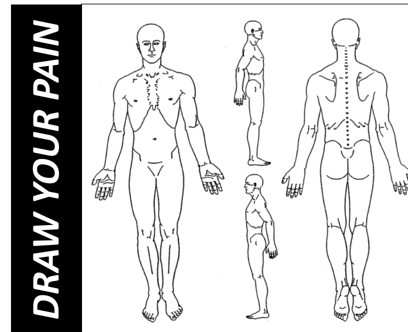
O 0-25% *Occasional* O 25-50% *Intermittent* **O** 50-75% *Frequent* **O** 75-100% *Constant*

Should Your Bill be Handled Using... *(please circle)*

Cash Credit Insurance Work Comp Ins. Accident Lien

Subscriber Name:____
Subscriber ID#:____
Group #:____
Health Plan:____
Your Occupation:____
Your Employer:____

DRAW YOUR PAIN



Please place the corresponding letter on the appropriate region on the diagram

D = Dull Ache
B = Burning
S = Sharp
SS = Shooting
N = Numbness
T = Tingling

IMPORTANT

O Recent Fever
O Chest Pain
O High Blood Pressure
O Steroid Use (Cortisone, Prednisone, etc.)
O Birth Control
O Dizziness / Fainting
O Numbness in Groin / Buttocks
O Pain at Night
O Menstrual problems

O Visual Disturbances
O Diabetes
O Osteoporosis
O Prostate Problems
O Urinary Problems
O Epilepsy / Seizures
O Abnormal Weight O Gain O Loss
O Marked Morning Pain / Stiffness
O Pain Unrelieved by Position or Rest

O Currently Pregnant, *# wks:*____________
O Stroke *(date):*______________________
O Cancer / Tumor *(explain):*_____________
____
O Surgeries:_____________________________
____
O Medications:___________________________
____
O Other:_________________________________

Certification & Assignment

Ownership of X-ray Films...

It is understood and agreed that payment to the Doctor for X-rays is for the examination of the film only. All X-ray negatives will remain the property of this office. X-rays are kept and maintained by this facility and may be viewed at any time while I am a patient at this office. It is also understood that at times an outside radiologist is used for additional evaluation of films taken in this office and films could at times be in transit between facilities.

Authorization for Care...

I certify that I and/or my dependent (s), have insurance coverage with___________________________________ and I assign directly to Jason Graney, DC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions provide by this office.

Use of Information

Jason Graney, DC may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. It is also understood that consultation by outside healthcare professionals may be used in collaborative efforts to acertain diagnostic information regarding my condition and for this use is hereby approved .

Patient's Signature____ ***Date***______________________

Signature of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Last Name First Name
H W C Tel. ( )