THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMTAION.

PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Grimm Chiropractic, we may use or disclose personal and health related information about you in the following ways:

***Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. *Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or maybe responsible for the payment of your services). *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:**

- **If we are providing health care services to you based on the orders from another health care provider.**
- **If we provide health care series to you in an emergency.**
- **If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.**
- **If there are substantial barriers to communication with you, but in our professional judgement we believe that you intend for us to provide care.**
- **If we are ordered by the courts or another appropriate agency.**
- **Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.**

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account or special event only associated with Grimm chiropractic. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

_____ _____

Name (printed) **Signature** **Date**

By signing above, I acknowledge I have read the above information and give full disclosure of my information.

CONFIDENTIAL

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

CASE HISTORY
(PLEASE PRINT)

Last Name _____ **First Name**_____ **Middle Initial** _____

Address _____ **City** _____ **State/Zip** _____

Home Phone _____ **Birth Date** _____ **Age** _____ **Sex** **M** **F**

Work Phone _____ **Employer** _____ **Number of Children** _____

Spouse's Name _____ **How did you hear about us** _____

Habits

- ☐ Smoking Per Day _____
- ☐ Alcohol Per Day _____
- ☐ Coffee/Tea Per Day _____
- ☐ Pop Per Day _____
- ☐ Water Per Day _____

Family History

	Diabetes	Heart	Kidney	Cancer
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother	☐	☐	☐	☐
Sister	☐	☐	☐	☐

Pain Area	When did pain begin	Pain Level									
_____	_____	1	2	3	4	5	6	7	8	9	10
_____	_____	1	2	3	4	5	6	7	8	9	10
_____	_____	1	2	3	4	5	6	7	8	9	10

GENERAL SYMPTOMS

Y N Dizziness
Y N Fainting
Y N Fatigue
Y N Fever
Y N Headache
Y N Loss of Sleep
Y N Numbness/Tingling
_____ Other

DIGESTIVE PROBLEMS

Y N Hiatal Hernia
Y N Colon Problems
Y N Gall Bladder
Y N Liver problems
Y N Diabetes
Y N Stomach Problems
Y N Pain over Stomach
_____ Other

URINARY PROBLEMS

Y N Blood in Urine
Y N Kidney Problems
Y N Bladder Problems
Y N Painful Urination
Y N Prostate Problems
_____ Other

SKIN OR ALLERGIES

Y N Allergy
Y N Itching
Y N Rash
Y N Hay Fever
_____ Other

EYE/EAR/NOSE/THROAT

Y N Eye Problems
Y N Ear Problems
Y N Nose Problems
Y N Throat Problems
Y N Thyroid Problems
Y N Frequent Colds
_____ Other

RESPIRATORY

Y N Asthma
Y N Bronchitis
Y N Chest Pain
Y N Difficulty Breathing
Y N Spitting Blood
Y N Spitting Phlegm
_____ Other

CARDIO-VASCULAR

Y N Pain Over Heart
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Previous Heart Problem
Y N Stroke
Y N Ankle Swelling
_____ Other

FOR WOMEN ONLY

Y N Cramps
Y N Irregular Cycle
Y N Painful Periods
Y N Pregnant
Y N Birth Control
_____ Other

MUSCLES AND JOINTS

Y N Neck Pain
Y N Mid Back Pain
Y N Low Back Pain
Y N Painful Tail Bone
Y N Stiffness
Y N Tremors
Y N Twitched
Y N Weakness
Y N Shoulder Problem
Y N Arm Problem
Y N Hand Problem
Y N Hip Problem
Y N Leg Problem
Y N Foot Problem
_____ Other

OPERATIONS AND PROCEDURE

Y N Appendix Operation
Y N Gall Bladder Operation
Y N Hernia Operation
Y N Stomach
Y N Thyroid
Y N Female Organs
Y N Spinal Taps
Y N Broken Bones
_____Other

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payments. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic health care and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____