



GRIEB  
CHIROPRACTIC CLINIC

Name \_\_\_\_\_ Patient ID # \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Text Message  Yes  No  
 E-mail \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver Lic. # \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M / F Status M S W D No.Children \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Wk Phone \_\_\_\_\_ Yrs Employed \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Health Insurance Subscriber Name \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

**PLEASE DESCRIBE YOUR CURRENT PROBLEM.**

**HOW DID YOUR PROBLEM BEGIN?**

**DATE PROBLEM BEGAN:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**WHAT TREATMENT HAVE YOU HAD FOR THIS PROBLEM IN THE PAST? (SURGERY, MEDICATIONS, INJECTIONS, PHYSICAL THERAPY, CHIROPRACTIC)**

**HAVE YOU HAD X-RAYS, MRI, OR OTHER TESTS FOR THIS PROBLEM? WHAT TESTS AND WHEN?**

**HAVE YOU BEEN UNDER PREVIOUS CHIROPRACTIC CARE?  YES  NO IF YES, PLEASE LIST**

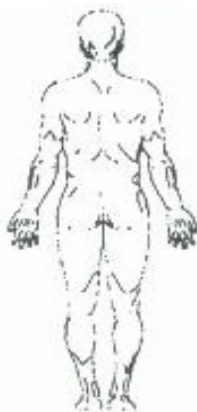
**WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)?**

**WHO REFERRED YOU TO GRIEB CHIROPRACTIC CLINIC?**

**CONTACT PREFERENCE**  Home Phone  Cell Phone  Text  Email

|   |         |   |   |   |   |   |   |   |   |   |                 |
|---|---------|---|---|---|---|---|---|---|---|---|-----------------|
| How bad is your pain? (Circle the number) | 0       | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10              |
|   | No Pain |   |   |   |   |   |   |   |   |   | Unbearable Pain |

- How often are your symptoms?  Constantly  Frequently  Occasionally  Intermittently
- Describe your current pain/symptoms:  Sharp/Stabbing  Throbbing  Aches  
 Dull  Soreness  Weakness  
 Numbness  Shooting  Gripping  
 Burning  Tingling  Other \_\_\_\_\_
- Since it began, is your problem:  Improving  Getting Worse  No Change
- What makes it better?  Nothing  Lying Down  Walking  
 Standing  Sitting  Movement  
 Exercise  Inactivity/Rest  Other \_\_\_\_\_
- What makes it worse?  Nothing  Lying Down  Walking  
 Standing  Sitting  Movement  
 Exercise  Inactivity/Rest  Other \_\_\_\_\_
- Can you perform your daily home activities?  Yes  Yes, only with help  Not at all  
 Do you exercise?  Yes, almost daily  Yes, occasionally  Not at all  
 Describe your job requirements:  Mainly sitting  Light labor  Heavy labor  
 Can you perform your daily work activities?  Yes, all activities  Only some  Not at all  
 Describe your stress level:  None to mild  Moderate  High



Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



GRIEB  
CHIROPRACTIC CLINIC

Name \_\_\_\_\_ Patient ID # \_\_\_\_\_ Date \_\_\_\_\_

If you have ever had a listed symptom in the past, please check the symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the Present Column. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT / THERAPY YOU RECEIVE.**

| Past                     | Present                  | Condition   | Past   | Present                  | Condition  |
|--------------------------|--------------------------|---|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain  | <input type="checkbox"/>   | <input type="checkbox"/> | Low Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss | <input type="checkbox"/>   | <input type="checkbox"/> | Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina  | <input type="checkbox"/>   | <input type="checkbox"/> | Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia  | <input type="checkbox"/>   | <input type="checkbox"/> | Pain in Ankle or Foot <input type="checkbox"/> Right <input type="checkbox"/> Left   |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm   | <input type="checkbox"/>   | <input type="checkbox"/> | Pain in Lower Leg/Knee <input type="checkbox"/> Right <input type="checkbox"/> Left  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   | <input type="checkbox"/>   | <input type="checkbox"/> | Pain in Upper Arm/Elbow <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma  | <input type="checkbox"/>   | <input type="checkbox"/> | Pain in Upper Leg/Hip <input type="checkbox"/> Right <input type="checkbox"/> Left   |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection   | <input type="checkbox"/>   | <input type="checkbox"/> | Pain in Upper Leg/Hip <input type="checkbox"/> Right <input type="checkbox"/> Left   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder  | <input type="checkbox"/>   | <input type="checkbox"/> | Shoulder Pain <input type="checkbox"/> Right <input type="checkbox"/> Left           |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps     | <input type="checkbox"/>   | <input type="checkbox"/> | Wrist Pain <input type="checkbox"/> Right <input type="checkbox"/> Left              |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Explain _____   | <input type="checkbox"/>   | <input type="checkbox"/> | Rapid Heart Beat   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains   | <input type="checkbox"/>   | <input type="checkbox"/> | Rheumatoid Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough   | <input type="checkbox"/>   | <input type="checkbox"/> | Scoliosis  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis   | <input type="checkbox"/>   | <input type="checkbox"/> | Stroke Date _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis   | <input type="checkbox"/>   | <input type="checkbox"/> | Swelling/Stiffness of Joints   |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/Irregular Bowel Habits   | <input type="checkbox"/>   | <input type="checkbox"/> | Tinnitus (Ear Noise)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions   | <input type="checkbox"/>   | <input type="checkbox"/> | Tumor Explain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes  | <input type="checkbox"/>   | <input type="checkbox"/> | Ulcer  |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression  | <input type="checkbox"/>   | <input type="checkbox"/> | Visual Disturbances  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash  | <input type="checkbox"/>   | <input type="checkbox"/> | Other _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing  | <b>Please Check any of the following that apply to you</b>                               |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness   | <input type="checkbox"/>   | <input type="checkbox"/> | Pregnancy, Number of Births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema   | <input type="checkbox"/>   | <input type="checkbox"/> | Birth Control Pills, Type _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis   | <input type="checkbox"/>   | <input type="checkbox"/> | Medications, Please List _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy  | _____  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst  | _____  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting  | <input type="checkbox"/>   | <input type="checkbox"/> | Hospitalization/Surgical Procedures, Please List                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  | _____  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue   | <input type="checkbox"/>   | <input type="checkbox"/> | Tobacco  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain <input type="checkbox"/> Left <input type="checkbox"/> Right      | <input type="checkbox"/>   | <input type="checkbox"/> | Alcohol  |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache  | <input type="checkbox"/>   | <input type="checkbox"/> | Drugs or Alcohol Dependence  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack Date _____   | <input type="checkbox"/>   | <input type="checkbox"/> | Coffee/Tea/Caffinated Soft Drinks, # Per Day _____                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion   | <b>If a family member has had any of the following, please mark the appropriate box:</b> |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepitis   | <input type="checkbox"/>   | <input type="checkbox"/> | Cancer   |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure   | <input type="checkbox"/>   | <input type="checkbox"/> | Rheumatoid Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Menstral Flow   | <input type="checkbox"/>   | <input type="checkbox"/> | Diabetes   |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon   | <input type="checkbox"/>   | <input type="checkbox"/> | Heart Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain  | <input type="checkbox"/>   | <input type="checkbox"/> | Lung Problems  |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorder   | <input type="checkbox"/>   | <input type="checkbox"/> | High Blood Pressure  |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones   | <input type="checkbox"/>   | <input type="checkbox"/> | Epilepsy   |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Problems   | <input type="checkbox"/>   | <input type="checkbox"/> | Chronic Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite  | <input type="checkbox"/>   | <input type="checkbox"/> | Chronic Headaches  |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control   | <input type="checkbox"/>   | <input type="checkbox"/> | Lupus  |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination   | <input type="checkbox"/>   | <input type="checkbox"/> | Other _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination   |  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS   |  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse Menstral Flow   |  |                          |  |

Do you have allergies to medications?  Yes  No

Do you have advanced directives?  Yes  No

In an emergency, would you want CPR?  Yes  No

In an emergency, would you want life support?  Yes  No

Do you have a permanent disability rating?  Yes  No Date received \_\_\_\_\_ Percentage \_\_\_\_\_

Pediatric Records (17 and younger)

Are your immunizations up to date?  Yes  No Please provide a complete record.

Present Weight \_\_\_\_\_ lbs Height \_\_\_\_\_ ft/in

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have a change in my health condition or health plan coverages in the future.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



Name \_\_\_\_\_ Patient ID # \_\_\_\_\_ Date \_\_\_\_\_

**Authorization To Perform X-Rays**

This is to acknowledge that Grieb Chiropractic Clinic has recommended that x-rays be taken so that a complete study and analysis may be made of my present condition. Therefore, Grieb Chiropractic Clinic is hereby authorized and directed to complete a radiographic examination in order to treat my present condition. To the best of my knowledge, I am not pregnant and Grieb Chiropractic Clinic has my permission to x-ray me for diagnostic interpretation.

Executed this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

Signed \_\_\_\_\_

Witness \_\_\_\_\_

**Consent For Treatment**

I hereby give consent to Grieb Chiropractic Clinic to administer whatever treatment is deemed necessary to treat my condition.

Executed this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

Signed \_\_\_\_\_

Witness \_\_\_\_\_

**Authorization To Release Information**

I hereby authorize the doctor and his staff of Grieb Chiropractic Clinic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process and claim for the reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

Executed this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

Signed \_\_\_\_\_

Witness \_\_\_\_\_

**Notice Of Assignment**

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of the agreement shall serve as the original.

Executed this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_

Signed \_\_\_\_\_

Witness \_\_\_\_\_



**HIPPA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
Grieb Chiropractic Clinic**

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Grieb Chiropractic Clinic's "NOTICE OF PRIVACY PRACTICES," revision date April 1, 2001.

As required by the Privacy Regulations, \_\_\_\_\_ from Grieb Chiropractic Clinic has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Grieb Chiropractic Clinic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

**REQUESTS:**

- I wish to file a "Request for Restriction" of my Protected Health Information
- I wish to file a "Request for Alternative Communication" of my Protected Health Information
- I wish to object to the following in the "Notice of Privacy Practices."

---

**I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

---

---

Signed form received by: \_\_\_\_\_

Good faith effort to obtain receipt: \_\_\_\_\_