GRAYBAR
CHIROPRACTIC & REHAB

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish optimal rehab program for you, and are completely confident we can help you recover your health. Thank you again for applying as a patient in our clinic.

_____

PATIENT NAME

_____

DATE COMPLETED

OUR PREMISE

"The families in our practice are healthier, happier and safer than the families that are not in our practice!"

CLINTON
600 Beaman Street | o: 910.596.2222 | f: 910.596.0222

WILMINGTON
2110 South 17th Street | o: 910.343.5250 | f: 910.343.5299

WALLACE
116 N. Norwood Street | o: 910.5285.7222 | f: 910.285.7229

Please identify the condition(s) that brought you to this office:

Primary: _____ Secondary: _____

Third: _____ Fourth: _____

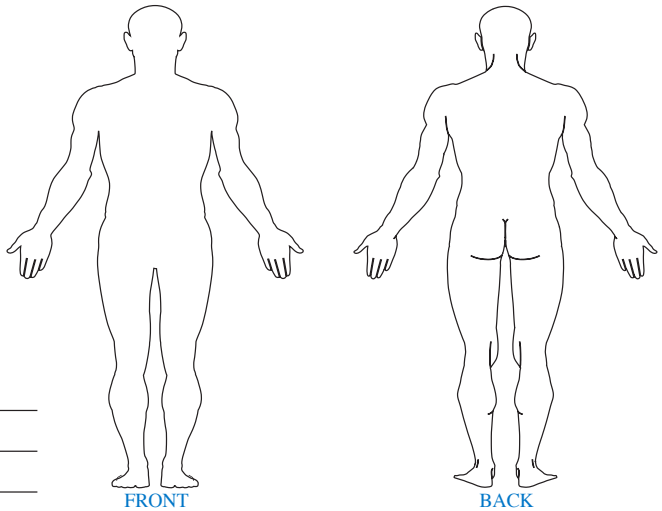
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number***:

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = Aching
B = Burning
P = Pain
SW = Swelling
G = Stabbing
M = Spasms
F = Stiffness
W = Weakness
N = Numbness
T = Tingling
O = Other



If you marked "O" for Other on any part, please explain below:

_____

_____

_____

Reason for this visit: _____

❑ Auto Accident YES / NO DATE: _____ / _____ / _____

❑ Work Related YES / NO DATE: _____ / _____ / _____

❑ Other : _____

_____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application

Describe: _____

When did these symptoms begin? _____ / _____ / _____ Are they: ❑ Constant ❑ Intermittent ❑ Activity-related

Are they getting worse? ❑ Yes ❑ No Do they interfere with: ❑ Work ❑ Sleep ❑ Hobbies ❑ Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? ❑ Yes ❑ No

If yes, explain: _____

Have you been treated for this? ❑ Yes ❑ No When were you last treated? _____ / _____ / _____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

Patient's Name: _____ **Date of Birth:** _____

Experience with Chiropractic

Have you seen a Chiropractor before? ❑ Yes ❑ No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? ❑ Yes ❑ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? ❑ Yes ❑ No Did they recommend a Home Health Care program? ❑ Yes ❑ No

If yes, what? How long were you treated? _____ Last treatment: _____ /_____ /_____

How did you respond? _____

Are you aware of any poor posture habits? ❑ Yes ❑ No Is there any history of spinal problems in your family? ❑ Yes ❑ No

If yes, explain: _____

_____

_____

Health & Lifestyle

Do you exercise? ❑ Yes ❑ No How often? _____ day(s) per week; Other: _____

What activities? ❑ Walking ❑ Running/Jogging ❑ Weight Training ❑ Cycling ❑ Yoga ❑ Pilates ❑ Swimming ❑ Other: _____

Do you smoke? ❑ Yes ❑ No How much? / How often? _____

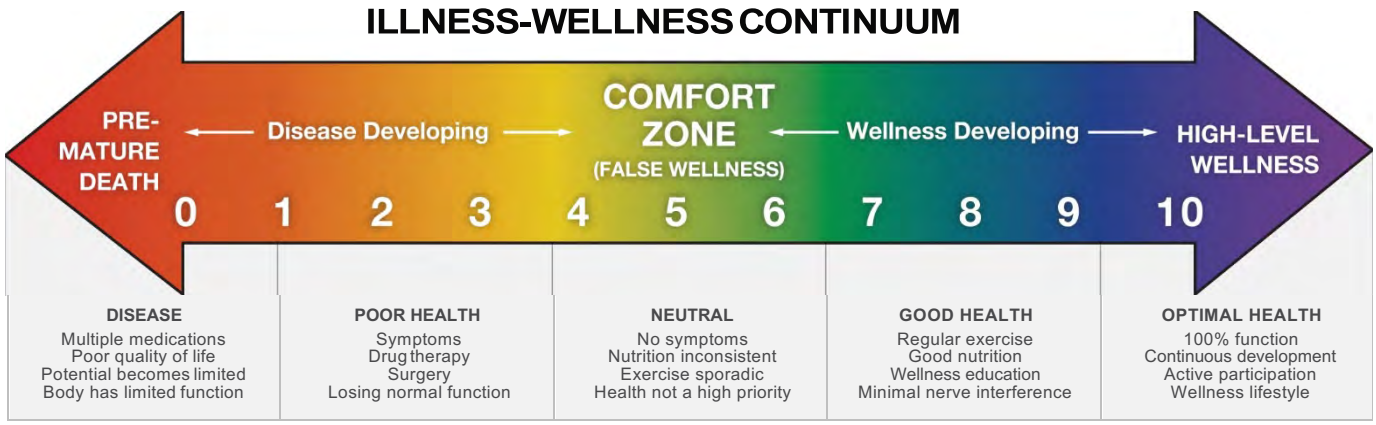
Do you drink alcohol? ❑ Yes ❑ No How much? / How often? _____

Do you drink coffee? ❑ Yes ❑ No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

What number do you think represents your health today? _____

What are your health goals?

What is one thing you want to get rid of? _____

What is one thing you have to get back to? _____

What is one thing you want to get back to? _____

Health Conditions *continued*...

OTHER

Please list any health conditions not mentioned: _____

_____

_____

_____

_____

Please list any medications (include name, dose, for what condition, and how long you've been taking it):

_____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed):

_____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago

____ Other: _____

_____

Patient's Name: _____ **Date of Birth:** _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES	EFFECT			
➢ Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
➢ Caring for Family	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
➢ Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Constant Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Constant Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Change Position Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Lifting at work (home)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Lifting overhead	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ PE (gym class activities)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Rendering Child care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Self Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Taking out Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Turning the head	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
➢ Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient Signature: _____ Today's Date: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ /_____ /_____

Patient's Signature _____ Date _____/_____/_____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date _____/_____/_____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date _____/_____/_____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at other procedures provided at Graybar Chiropractic and Rehabilitatioin have been explained to me to my satisfation and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any menas, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/___ ☐

Patient or Authorized person's Signature Date Witness Initials

HIPAA Notice of Privacy Practices

Graybar Chiropractic & Rehab Centers
116 Norwood St Wallace, NC 28466 910-285-7222
2110 South 17th Street Wilmington, NC 28409 910-343-5250
600 Beaman Street Clinton, NC 28328 910-596-2222

For Office Use Only:

Signature below is acknowledgement that you have received/reviewed our **HIPAA Notice of our Privacy Practices.**

Patient Name_____

Signature_____Date_____

Representative Name: _____

Witness Signature_____Date_____

We have built this practice on our reputation of patient satisfaction and trust. With this in mind, we would love the opportunity to share with your friends and family the care that we will extend to you in our offices.

Please INITIAL the boxes below which you feel comfortable with:

____ *Telling friends, family and/or other clients via phone or in person that you are at our office*

____ *Using of your NAME on a personal referral / reference board in our reception area*
____ *Using of your NAME on our LIFETIME WELLNESS WALL*
____ *Using of your NAME and PICTURE ID on your office Televisions*
____ *Discussing your clinical success with other patients in the office*

____ *Allowing to send you a birthday card on your special day*

____ Receiving text messages from our offices regard appointment notice

Please include your cell phone number _____

____ Receiving email messages from our offices regard appointment notice

Please include your email address _____

____ ***Please do not disclose any personal information, diagnosis and/or treatment with anyone except:_____***

Patient Signature _____ Date_____

Staff Signature _____

QUADRUPLE VISUAL ANALOGUE SCALE Patient Name _____ Birthdate: _____

Today's Date _____

Chief Complaint (s)/conditions

1. _____
2. _____
3. _____
4. _____

PLEASE READ INSTRUCTIONS CAREFULLY: Please indicate the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain and pain at its best and worst.

1 – What is your pain RIGHT NOW?

NO PAIN _____ WORST POSSIBLE PAIN

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

NO PAIN _____ WORST POSSIBLE PAIN

0 1 2 3 4 5 6 7 8 9 10

3 – **What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

NO PAIN _____ WORST POSSIBLE PAIN

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst?)

NO PAIN _____ WORST POSSIBLE PAIN

0 1 2 3 4 5 6 7 8 9 10

_____OATS SCORE _____Goal (Add 1 + 2 + 4 / 3 X 10 = OATS)

Initial Program Date _____ Visits recommended during this treatment phase _____

End Program Date _____ Visits completed during this treatment phase _____

Treatment Recommendations / Re-evaluation 2 weeks 4 weeks 6 weeks

1. _____Visit recommendation _____
2. _____
3. _____
4. _____
5. _____

Patient Signature _____ Staff Representative _____

2-2020