

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip code _____

E-Mail address _____ Birth Date _____ Age _____

Marital Status M S W D How many children ? _____ Social Security #: _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Name of Spouse/Nearest Relative _____ Phone Number _____

Referred By _____ Date of Last Physical _____

Name of Primary Doctor _____ Address _____

Name of Primary Insurance Company _____

Name of Secondary Insurance Company _____

Purpose of this Appointment _____

Other Doctors seen for this Condition _____

Have you been treated for any health condition by a physician in the last year ? ___yes ___no

Describe _____

Remarks and additional information: _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of Person Responsible for Payment: _____

Are you Insured? ___YES ___NO Company: _____

I understand and agree that health and accident insurance policies are an arrangement between in insurance carrier and myself. Furthermore, I understand that the Grant Chiropractic Health Center, LLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Grant Chiropractic Health Center, LLC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. 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 authorize the release of all medical records/information to my insurance company referring and /or primary care physician. Furthermore, I authorize and request that all insurance payments be made directly to **Dr. Carol Grant**.

Patient's signature: _____ Date: _____

Guardian/Spouse's Signature: _____ Date: _____

Information Taken By: _____ Date: _____

All attempts will be made to keep your health care information confidential. If you have questions or concerns in this matter, please speak directly to Dr. Grant. With your signature, you grant permission for this office to use your personal information in the normal course of your treatment in this office including phone calls to remind you or reschedule your appointments.

Signature _____ Date _____

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
a. Any of your usual work, housework, or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
c. Getting in or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about one flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
Column Totals:					

Score: _____/80

Error (single measure): ± 5 scale points

MDC: 9 scale points

MCID: 9 scale points

NAME _____ DATE _____