Graddy Chiropractic
4625 s Harvard ste.200
Tulsa, ok 74135
P: 918-861-4748 F: 918-861-4897

General Information

First Name_______________________ Middle Name_______________________

Last Name_______________________ Suffix_______________________

Called Name_______________________ Address _______________________

City_______________________ State_______________________

Zip Code _______________________ Home Phone_______________________

Work Phone_______________________ Cell Phone_______________________

Email_______________________ Married Single Other_______________________

Birthdate_______________________ Referred By_______________________

Sex: Male Female SSN_______________________

*Appointment reminders will be sent by text unless specified otherwise.

PATIENT INTAKE

Are your present problems due to an injury: Y N If yes enter the date of injury ______________

Was the injury: Job related Auto Accident Personal Injury Other_______________________

Has the accident been reported: Y N If yes, to whom: Employer Auto carrier Other____________

Briefly describe the accident, injury or illness:

____

____

List any tests, studies or medications received for this condition:
Tests____
Medication____
List any medication currently taking:

____

____

Were you admitted to the hospital for this condition: Y N If yes what hospital_____________________
Date admitted: _________________ Date released: _________________ Length of stay: _____________

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Name: ______________________________

For Office Use Only

Date: ________________

Acct #: ______________

List symptoms you are experiencing today: Choose the severity level associated with each symptom

________________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

Frequency of Pain ☐Occasional ☐Intermittent ☐Frequent ☐None

Type of Pain ☐Aching ☐Burning ☐Dull ☐Pulling ☐Sharp ☐Shooting ☐Stabbing ☐Stinging ☐Throbbing☐None

________________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

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Type of Pain ☐Aching ☐Burning ☐Dull ☐Pulling ☐Sharp ☐Shooting ☐Stabbing ☐Stinging ☐Throbbing☐None

________________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

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Type of Pain ☐Aching ☐Burning ☐Dull ☐Pulling ☐Sharp ☐Shooting ☐Stabbing ☐Stinging ☐Throbbing☐None

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________________________ ☐(1) Very Mild ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Remarkably Severe

Frequency of Pain ☐Occasional ☐Intermittent ☐Frequent ☐None

Type of Pain ☐Aching ☐Burning ☐Dull ☐Pulling ☐Sharp ☐Shooting ☐Stabbing ☐Stinging ☐Throbbing☐None

Do you have any current work restrictions due to this condition?
Off work: ☐Yes ☐No ☐Previously From: _____ To: __________
Light duty: ☐Yes ☐No ☐Previously (If yes, what are/were your restrictions?)

____

Do you suffer from any condition other than that for which you are now consulting us? ☐Yes ☐No

____

List any past conditions you may have had:

____
____
____
____
____
____

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HABITS

☐Current Every Day Smoker ☐Current Some Day Smoker
☐Former Smoker ☐Never Smoker
☐Drinking Alchohol: (Cups/day): ____ ☐Coffee Cups/Day: ____
☐Soft Drink Bottles or Cans/Day: ____ ☐Water Cups/Day: ____

EXERCISE

☐None
☐Moderate
☐Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐

Have you taken any medications in the past? ☐Yes ☐No If yes, which ones?: ____________________

Do you have allergies? ☐Yes ☐No If yes, which ones?: ____________________

Have you ever had any surgeries? ☐Yes ☐No (If yes, enter type and approximate date of surgery.)

____

____

Have you ever had X-rays taken? ☐Yes ☐No When? ____________________

For what ailments were these X-rays taken? ____________________

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Name: ______________________________

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Date: ______________

Acct #: ______________

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ☐ Allergy(What) __________
- ☐ Bronchitis
- ☐ Headache
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting

GASTRO-INTESTINAL

- ☐ Belching or Gas
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall Bladder
- ☐ Hemorrhoids (piles)

EYE/EAR/NOSE/THROAT

- ☐ Asthma
- ☐ Deafness
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ear Noises
- ☐ Thyroid Problems

RESPIRATORY

- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Spitting Blood
- ☐ Spitting Phlegm

GENERAL SYMPTOMS

- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Numbness in __________
- ☐ Wheezing

GASTRO-INTESTINAL

- ☐ Nausea
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Heart Burn
- ☐ Bloody Stools

EYE/EAR/NOSE/THROAT

- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Pain in Eyes
- ☐ Poor Vision
- ☐ Blurred Vision
- ☐ Sinusitis

GENITO-URINARY

- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Urination Control
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Painful Urination

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ☐ Appendicitis
- ☐ Arthritis
- ☐ Goiter
- ☐ Mumps
- ☐ Polio
- ☐ Lumbago
- ☐ Alcoholism
- ☐ Cancer
- ☐ Anemia
- ☐ Pneumonia
- ☐ Epilepsy
- ☐ Influenza
- ☐ Chicken Pox
- ☐ Tuberculosis
- ☐ Eczema
- ☐ Venereal Disease
- ☐ Heart Disease
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Mental Disorder
- ☐ Pleurisy
- ☐ Diabetes
- ☐ Whooping Cough
- ☐ HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: ______________________________ **Date:** ____________________

PLEASE INITIAL NEXT TO EACH POLICY

X______ **ACKNOWLEDGMENT OF FINANCIAL POLICY**

- AUTHORIZATION FOR CARE AND TREATMENT: I request and consent to the rendering of health care services, which may include but not be limited to diagnosis and treatment services by the Doctors and the staff at Graddy Chiropractic.
- FINANCIAL AGREEMENT: I agree to pay all fees charged by Graddy Chiropractic and its associates for the health care services from my health care plan or any other third-party. I understand that, although Graddy Chiropractic may submit a payment request to my health plan or another third-party, I will be responsible for payment of all charges.
  I also understand that I will be required to make any co-payments or co-insurance payments established by my health plan at the time service is provided.
  I agree to pay interest at the rate of 1.5% per month on any charges which are not paid on my account within 45 days of the date of billing. I further agree to pay a RETURNED CHECK CHARGE OF $25.00 PLUS ANY BANK CHARGES per check for any check that is returned unpaid by my bank for any reason.
- AUTHORIZATION FOR DIRECT PAYMENT AND ASSIGNMENT OF CLAIM: I, the undersigned patient in consideration of services rendered, herby assign and transfer access to all health benefits as it pertains to my treatment and payments for such services, to Graddy Chiropractic, Dr. Christina Graddy. A copy of this assignment shall be valid and effective as if it were the original.
- CANCELLATION/ NO SHOW APPOINTMENT: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee this will not be covered by your insurance company.
- RELEASE OF INFORMATION TO THIRD PARTY INSURANCE AND ANY REFERRALS MADE ON BEHALF OF TREATMENT: I authorize Graddy Chiropractic and its associates to release information from my health records to any health care provider involved in my care and to my health plan or to any third-party payer which is or may be liable for all or part of the charges of Graddy Chiropractic and its associates.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND AGREE TO ITS CONTENTS, I FUTHER ACKNOWLEDGE THAT I AM THE PATIENT IDENTIFIED ABOVE OR THAT I AM AUTHORIZED BY LAW TO CONSENT TO TREATMENT OF THE PATIENT.

X______ **PREGNANCY WAIVER**

I hereby acknowledge that the Dr.(s) at Graddy Chiropractic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure

X______ **PATIENT ACKNOWLEDGMENT AND RECIEPT OF NOTICE OF PRIVACY PRACTICES**

hereby acknowledge that I received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

X______ **RADIOLOGIST RELEASE**

I understand that central plains Radiologic services, PA (hereinafter referred to as CPRS) is an outside radiology practice and that my DR. uses their services for radiologic consultation services and will/may send my X-rays or other diagnostic imaging to CPRS for professional consultation. If the patient is a minor child, my signature here also authorizes the evaluation and current /future treatment of my child by a CPRS staff.

I acknowledge that I have been offered a copy or CPRS privacy notice, in force as of april14,2003.

Educational materials- by signing below I give permission to Dr. Gould/ Dr. Graddy to use my images and case history (without identification) for the purposes of education.

Print Patient Name ______________________________ **Date**____________

Patient/Guardian Signature______________________________ **Date**____________

Witness______________________________ **Date**____________

X________INFORMED CONSENT FOR CHIROPRACTIC CARE WITH GRADDY CHIROPRACTIC/DR. CHRISTINA GRADDY AND OR ITS ASSOCIATES

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "spinal manipulation". As the joints in your spine are moved you may experience a "pop" as part of the process. There are certain complications that can occur as a result of a spinal manipulation. These complications include but are not limited to muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Homers syndrome (also known as oculosympathetetic palsy) costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I am aware of these complications and in order to minimize the occurrence I will take precautions; these precautions include but are not limited to taking a detailed history and examining you for any defect which would cause a complication. This examination may include X-rays. The use of X-ray may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history. Again, it is the responsibility of the patient to make it know, or to learn through health care procedures whatever he/she is suffering from. I understand that if I am accepted as a patient by a physician at Graddy Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request

Release of health information

List below all persons that may talk with this clinic about your account.

____

____

I acknowledge that I have been informed that any names listed above are allowed to inquire or discuss any medical treatment/ Financial information generated with Graddy chiropractic and its staff.

Print Patient Name______________________________ **Date**__________

Patient/Guardian Signature__________________________ **Date**__________

Witness______________________________ **Date**__________