BRUCE J. GRANDSTAFF, D.C.

"Health is not merely the absence of disease, it is the balance of mind, body and soul."

PATIENT INFORMATION

DATE	I.D. NO.

Patient Name: _____ Birth Date: _____ Age: _____
First Middle Last

Marital Status: Single Married Divorced Widowed Child Sex: Male Female

Mailing Address: _____
Street City State Zip Code

Social Security #: _____ Cell Phone: ( ) _____ Home Phone: ( ) _____

Employer Name: _____ Work Phone: ( ) _____

Driver's License Number: _____

Referred to This Office By: _____

Credit Card: VISA MASTERCARD CC #: _____ Exp. Date: _____

Note: This information must be filled out. Your credit card information is kept confidential and will only be used if patient balance is due. 3 Digit Security Code: _____

Your Automobile Insurance (Fill out *only* if you're here for an auto accident.)

Note: In Idaho we are required to bill your auto insurance if you have Personal Injury Protection on your policy, even if the third party is at fault.

Insurance: _____
Name Address City State Zip Code

Policy #: _____ Claim #: _____ Date of Accident: _____

Adjuster: _____ Phone #: ( ) _____ ext: _____

Third Party Automobile Insurance

Note: In Idaho we are required to bill your auto insurance if you have Personal Injury Protection on your policy, even if the third party is at fault.

Insurance: _____
Name Address City State Zip Code

Policy Holder: _____ Claim #: _____ Phone #: ( ) _____

Please Continue on Back Side of Page

Consent to Treatment of Minor (For patients 0-18yrs of age.)

I, being the parent or guardian of_____ , a minor the age of _____ do hereby consent, authorize and request Dr. Bruce J. Grandstaff to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold him free and harmless from any claims, suits for damages, or complications which may result from such treatment.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

HIPPA Privacy

I understand that some services, though my insurance may confirm coverage via the phone, is not a guarantee of payment i.e. emotional work, detoxing, ASERT and cold laser therapies. In such cases I, the patient, take full responsibility of payments for any such services.

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation, therapies, and/or nutritional supplementation. The Doctor will not be held responsible for any pre-existing medical diagnosed conditions, nor for any medical diagnosis.

I grant permission for BRUCE J. GRANDSTAFF, D.C. and staff to exchange medical information with my referring physician, to the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of portions of the patient medical records to my insurance company.

I understand that it is the desire of BRUCE J. GRANDSTAFF, D.C. and staff to use my name, address and/or telephone number for the purpose of contacting me to advise me about appointments, health related meetings and/or products. The use of this information is intended to make my experience more efficient, productive and to further enhance my access to quality health care.

I understand that it is the desire of BRUCE J. GRANDSTAFF, D.C. and staff to keep my care confidential, though at times the Doctor moves from patient care area to patient care area and may leave the door ajar between rooms. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and/or staff. Because of various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information, I allow my authorization of such incidents.

I understand that if I am not at home to receive an appointment reminder, a message may be left on my answering machine or with whomever answers the call. Also, I understand that information regarding my health care or about the status of my account is sent to my home address.

I agree never to rescind this document and that a rescission will not be honored.

PATIENT SIGNATURE: _____ DATE: _____

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PATIENT HEALTH

Current Health Condition

Patient Name: _____

Purpose of This Appointment: _____

Circle Your Symptoms:
Neck Pain Mid Back Pain Low Back Pain Headaches Arm Pain/Carpel Tunnel Leg Pain
Organ Dysfunctions *(i.e. G.E.R.D., Ulcers, Urinary Frequency, Bladder Infections, Constipation, Kidney Stones, etc.)*

Other Doctors Seen for These Symptoms: Yes No Who? _____ When? _____

Type of Treatment: _____ Results: _____

When Did These Symptoms Begin? _____ Have These Symptoms Occurred Before? Yes No

The Onset Was: Sudden Gradual

Are Symptoms: Job Related Auto Accident *(Date:* _____ *)* Fall Other: _____

Are Symptoms:
Staying the Same Constant Getting Better Getting Worse Off and On
Mild Moderate Severe

Circle Any of the Following Activities That Increase Your Symptoms:
Bending Twisting Sitting Laying Down Walking Sneezing Coughing
Standing Standing Up From a Chair Driving or Riding in a Car

Symptoms Decrease When You: Lay Down Sit Stand Walk

Do the Symptoms Interfere With Your Sleep? Yes No

Are You Taking Supplements *(i.e. Vitamins, Herbs, Homeopathics)*? Yes No

What Are Your Health/Wellness Goals and How Would You Like Us to Help You Achieve Them? _____

_____

_____

Are You Here For *Temporary Relief* or for *Wellness Care*? _____

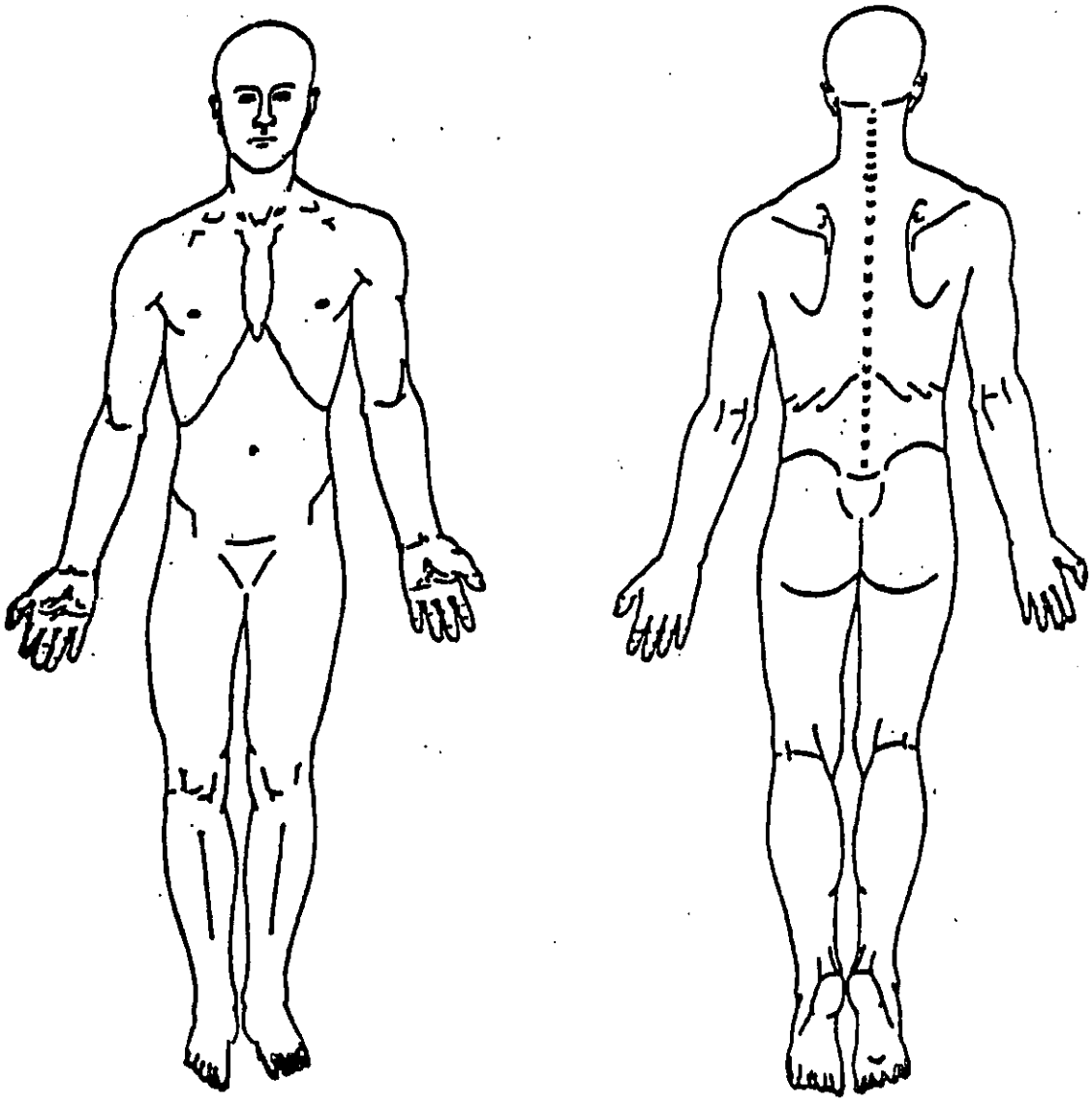
We Are Here to Help You Reach and Maintain Your Optimal Health Potential. We Believe Your Body is Made to Be Healthy and Symptom Free. With Your Dedication as the Patient and Our Dedication to You as Your Doctor We Can Reach This Goal!

Please Continue on Back Side of Page

Please Complete This Drawing Carefully:

1. Mark in *Red Pen* All Scars (Internally and Externally).
2. Mark in *Blue/Black Pen* the Appropriate Symbols Associated With the Symptoms You are Feeling.

- Sharp Pain: . . .
- Dull and Aching Pain: **XXX**
- Pins and Needles: / / /
- Numbness: **OOO**
- Burning Pain: - - -
- Other: ??? _____



Please Continue on Following Page

Health History

Patient Name: _____

Please Circle and Describe the Following:

Major Surgeries/Operations:
Appendectomy Tonsillectomy Gall Bladder Hernia Neck/Back Surgery Broken Bones
Other _____

Major Accident or Falls: _____

Previous Chiropractic Care: None 0-6 Months Ago 6-12 Months Ago 1-2 Years Ago 2+ Years Ago

Doctor's Name and Approximate Date of Last Visit: _____

X-Rays: Yes No

Do You Wear a Shoe Lift/Orthotics? Yes No

Circle if You Are Currently Taking Any of The Following Medications:

Corticosteroids	Blood Thinners	Blood Pressure Medicine	Insulin
Hormones	Birth Control	Nerve Pills	Other
Pain Killers/Muscle Relaxants	Anti-Inflammatory	Aspirin/Tylenol, etc.	

General Health Problems:
Digestive Stomach Gas/Acid Constipation Diarrhea Menstrual/PMS/Menopause Dizziness

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of health/wellness care.

Circle Any of the Following Diseases You Have Had:

Pneumonia	Mumps	Influenza
Rheumatic Fever	Small Pox	Pleurisy
Polio	Chicken Pox	Arthritis
Tuberculosis	Diabetes	Epilepsy
Whooping Cough	Cancer	Mental Disorders
Anemia	Heart Disease	Eczema
Measles	Thyroid	

Have You Been Tested HIV Positive? Yes No

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Circle Any of the Following You Have Had the Past 6 Months:

Musculo-Skeletal:
Low Back Pain
Pain Between Shoulders
Neck Pain
Arm Pain
Joint Pain/ Stiffness
Walking Problems
Difficult Chewing/
Clicking Jaw
General Stiffness

Gastro-Intestinal:
Poor/ Excessive Appetite
Excessive Thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Problems
Gall Bladder Problems
Weight Trouble
Abdominal Cramps
Gas/ Bloating After Meals
Heartburn
Black/ Bloody Stool
Colitis

C-V-R:
Chest Pain
Short Breath
Blood Pressure Problems
Irregular Heartbeat
Heart Problems
Lung Problems/ Congestion
Varicose Veins
Ankle Swelling
Stroke

Nervous System:
Nervous
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/ Depression
Fainting
Convulsions
Cold/ Tingling Extremities
Stress (Emotional/Mental)

Genito-Urinary:
Bladder Trouble
Painful/ Excessive
Urination
Discolored Urine

EENT:
Vision Problems
Dental Problems
Ear Aches
Hearing Difficulty

General:
Fatigue
Allergies
Loss of Sleep
Fever
Headaches

Male/ Female:
Menstrual Irregularity
Menstrual Cramps
Vaginal Pain/ Infection
Breast Pain/ Lumps
Prostate/ Sexual Dysfunction
Other Problems: _____

_____

_____

When Was Your Last Period? _____

Are You Pregnant? Yes No Not Sure