



Welcome to Gerrish Chiropractic!

Please complete the following pages as thoroughly as possible. This confidential history will be part of your medical records and will help us better understand your overall health. Thank you!

Name: _____ DOB: _____
SSN: _____ Gender: Male / Female Marital Status: S / M / P / D / W
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Cell: _____
Email: _____ E-Statements: Yes / No
Emergency Contact: _____ Phone: _____
Primary Care Doctor: _____ Phone: _____
Employment Status: FULL TIME / PART-TIME / UNEMPLOYED / RETIRED / STUDENT
Employers Name: _____ Phone: _____
Who is responsible for this account? _____
Relationship to Patient: _____ Payment: Self-Pay by Request / Submit to Insurance
Insurance Company: _____ Policy #: _____
Subscriber's Name: _____ DOB: _____ SSN: _____

Assignment and Release for Insurance

I certify that I, and/or my dependent(s), have insurance coverage and assign to Gerrish Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the doctor or chiropractic office to contact me in regards to treatment as well as promotional activities. Gerrish Chiropractic Center may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services determining insurance benefits or the benefits payable for related services.

Patient or Guardian Signature: _____ Printed: _____
Relationship to Patient: _____ Date: _____

Reason for today's visit:

☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness

Are you in pain: Yes / No

Rate your pain with the following scale: (circle one)

None 1 2 3 4 5 6 7 8 9 10 Intense

WOMEN ONLY:

Are you pregnant? Yes / No How many months: _____

Symptoms you have experienced in the past 6 months:

- ☐ Low Back Pain
☐ Pain Between Shoulder Blade
☐ Neck Pain
☐ Tension/Migraine Headaches
☐ Tired/ Fatigued

☐ Tension Across Top of Shoulders
☐ Numbness/Tingling in Arms or Hands
☐ Numbness/Tingling in Legs or Feet
☐ Dizziness
☐ Ringing of Ears

☐ Nervous
☐ Difficulty Sleeping
☐ Allergies
☐ Digestive Problems
☐ Weight Problems

☐ Other: _____

PAIN DIAGRAM

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

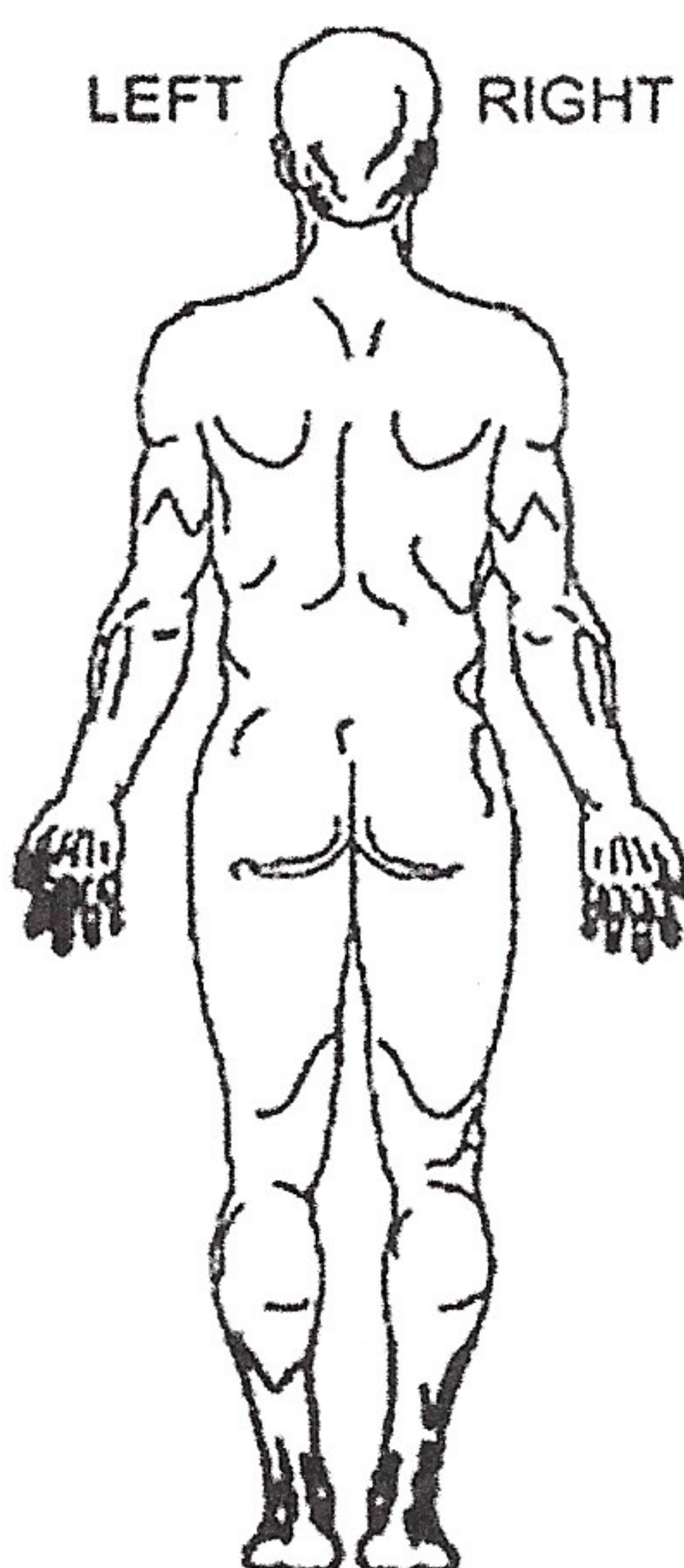
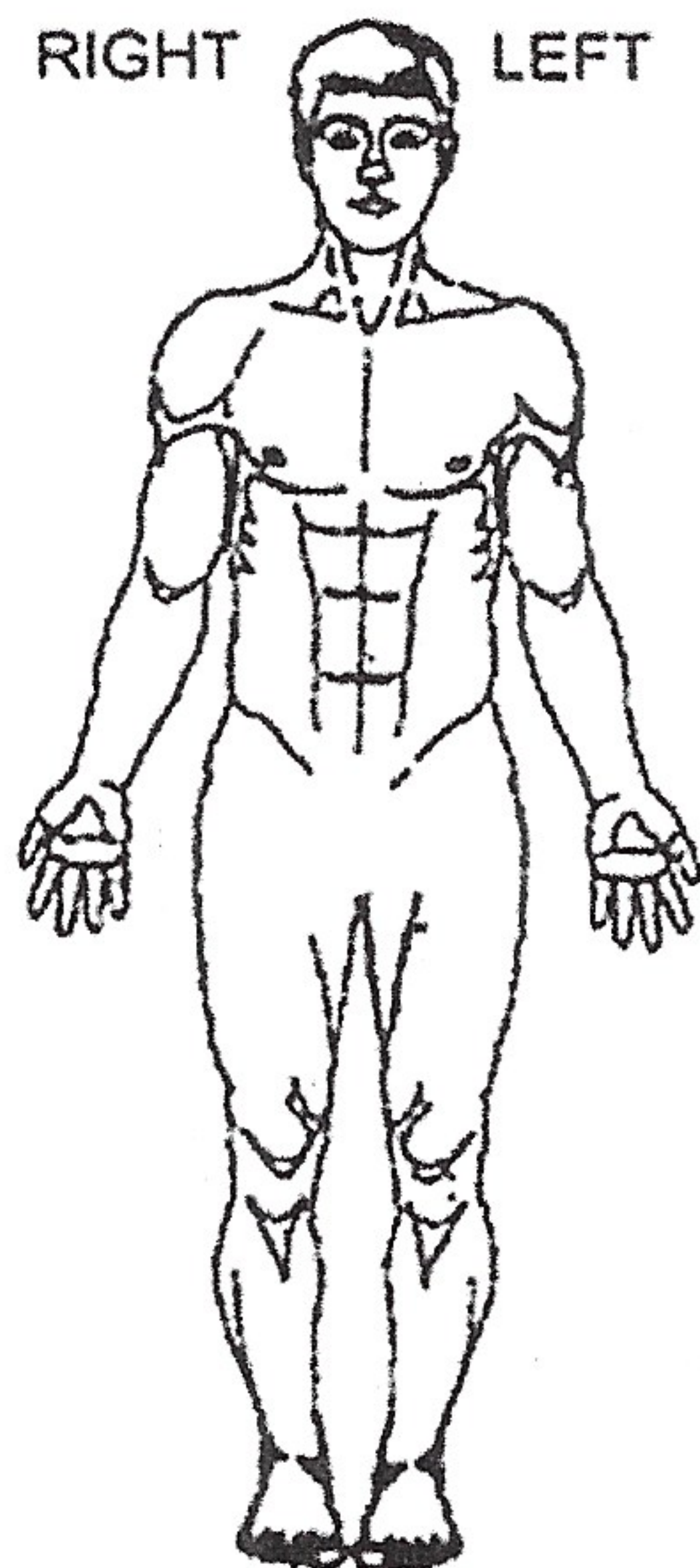
P. PAIN
T. TINGLING
N. NUMBNESS
B. BURNING
S. STIFFNESS

FRONT

BACK

RIGHT LEFT

LEFT RIGHT



Initial Here _____

What caused the pain? _____

When did the pain start? _____

What makes the pain better? _____

What have you done to treat the pain? _____

What makes the pain worse? _____

Weight: _____

Height: _____

Exercise: Light / Moderate / Heavy

Type: _____

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress Level

Packs/Day _____

Drinks/Week _____

Cups/Day _____

Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had

Description

Date

Falls

Head Injuries

Broken Bones

Dislocations

Surgeries

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____

Pharmacy Phone (____) _____

Gerrish Chiropractic Center

276 State Highway 3, Bar Harbor, ME 04609

phone: 207-288-3980 fax: 207-288-8030

www.gerrishchiro.com

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. This Notice will be available to you in the future at your request. We reserve the right to change our privacy practices that are described in this Privacy Notice, in accordance with applicable law. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____

Date of Birth: _____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Gerrish Chiropractic Center**.

I understand that the Notice describes the uses and disclosures of my protected health information by **Gerrish Chiropractic Center** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

Gerrish Chiropractic Center

Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other therapy procedures to be performed on myself or on _____ by the doctor. I also consent to the procedures performed by his trained staff assistants under direct instruction and supervision.

I have had an opportunity to discuss with the doctor or other office personnel the nature and purpose of chiropractic adjustments and other therapy procedures. I understand that the practice of neither chiropractic or medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee to results has been made to, nor relied upon by, me, and I wish to rely on the doctor to exercise judgment during the course of the procedures which he feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic procedures is very low, anyone undergoing chiropractic adjustments, physical therapy services or joint manipulation procedures should know of possible complications, which have been alleged. These include, but are not limited to; burns, fractures, disc injuries, strokes, dislocations, sprains, increase or worsening of symptoms and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had the opportunity to ask questions about its' contents, and by signing below, acknowledge my understanding of its contents.

Date: _____

Patient Name: _____

Patient Signature: _____

Relationship or Authority if not signed by patient: _____

Signature of Witness: _____
