Your Health History

Date _____

greystone CHIROPRACTIC

Full Name _____ **Date of Birth** _____

Home Street Address _____

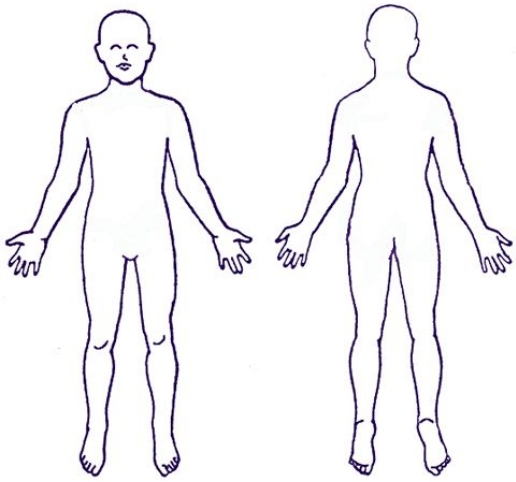
City, State, Zip _____

Cell phone _____ **Home or Work** _____

Email _____ **Is it okay to send your report/s via email?** _____

Who can we thank for referring you to us? _____

Please mark area/s of concern on the diagram:



Please describe health concerns:

_____

_____

_____

Please answer the following questions:

1. **How long have you been experiencing this?**
2. **Rate the intensity from 1-10 with 10 being most severe (if symptoms are involved)**
3. **Do you know how it happened?**
4. **Is it constant or random?**

What makes it worse? _____

What makes it better? _____

Does this interfere with: Work ____ **Leisure** _____ **Sleep** _____ **Home life** _____ **Other** _____

Have you seen anyone else for this? MD _____ **Naturopath** _____ **Other** _____

Who and when? _____

What was their diagnosis/recommendation? _____

General History

Do you have any medical conditions or diagnoses?

_____

Lost any weight without trying recently? _____ **If yes, how many pounds?** _____

Medications? If yes, please list: _____
Do you smoke? _____ Any family history of disease or cancer? If yes please list:

_____

_____

_____

Do you take supplements? If yes, please list: _____

_____

Any surgeries or hospitalizations? _____

_____

Please check the following if they are current or have happened in the last 6 months:

❑ Headaches/migraines	❑ Digestive issues	❑ Eyes bothered by light
❑ Neck pain	❑ Menstrual difficulties	❑ Fainting
❑ Mid back pain	❑ Fertility issues	❑ Urinary issues
❑ Low back pain	❑ Ear issues	❑ Cold feet
❑ Pins/needles:arms/hands	❑ Gallbladder or liver issues	❑ Cold hands
❑ Pins/needles:legs/feet	❑ Ringing or buzzing in ears	❑ Prolonged diarrhea
❑ Dizziness	❑ Irritability/mood swings	❑ Ulcers
❑ Fatigue	❑ Depression	❑ Seizures
❑ Vertigo	❑ Thyroid issues	❑ Mental fog/concentration issues
❑ Allergies	❑ Loss of smell or taste	❑ Autoimmune issues
❑ Cancer _____ (which)	❑	❑

Rate your level of stress (1-10, 10=severe): **Home: _____**
Work: _____
Overall: _____

Any other things that would be good for us to know about your life and/or health?

_____

_____

_____

_____

HIPPA Agreement

Consent for treatment, payment and healthcare operations

I, _____ consent to the use of my Protected Health Information (PHI) by Dr. Lee Goldenberg, and/or staff of Birmingham Wellness LLC, d/b/a Greystone Chiropractic or (hereafter "the practice"), for the purpose of providing treatment for me, for purposes relating to the payment of services rendered to me, and for the practice's general healthcare operations. Healthcare operations may include, but are not limited to: quality assessment activities, credentialing, business management, or general operational activities.

I understand the practice's diagnosis, treatment plan, and other evaluation and management information may be conditioned upon by consent as evidenced by my signature on this document. For purposes of consent, PHI means any information, including demographic information, created or received by the practice, that relates to my past, present or future physical or mental health or condition; the provision of healthcare to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my PHI for the purposes of treatment, payment, or healthcare operations of the practice, but the practice is not required to agree to these restrictions. However if the practice agrees to restriction I request, the restriction is binding on the practice until which time I remove the restriction in writing.

I understand that I have the right to review the practice's notice of privacy practice prior to signing this document. The notice of privacy practices describes my rights and the practice's duties regarding the types of uses and disclosures of my PHI. I have the right to revoke this consent, in writing, at any time, except to the extent that physician or the practice has acted in reliance on this consent.

I understand that I am responsible for the charges I incur at the practice, whether or not my insurance policy covers chiropractic care or office visits. Some policies cover different amounts, and it is my responsibility to know and understand what my insurance coverage offers and what I am responsible for.

_____

Name Signature Date