Dr. Donald E. McGriff, DC MUAC

PATIENT HEALTH QUESTIONNAIRE

Personal Information Date:____

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Marital Status: S M D W Name of Spouse: _____
Phone: _____ Cell: _____
Work: _____ ext._____ Ok to call at work? Yes/No
Occupation: _____ Employer: _____
Business Address: _____

Who Referred You To Our Office or How Did You Hear About Us? _____

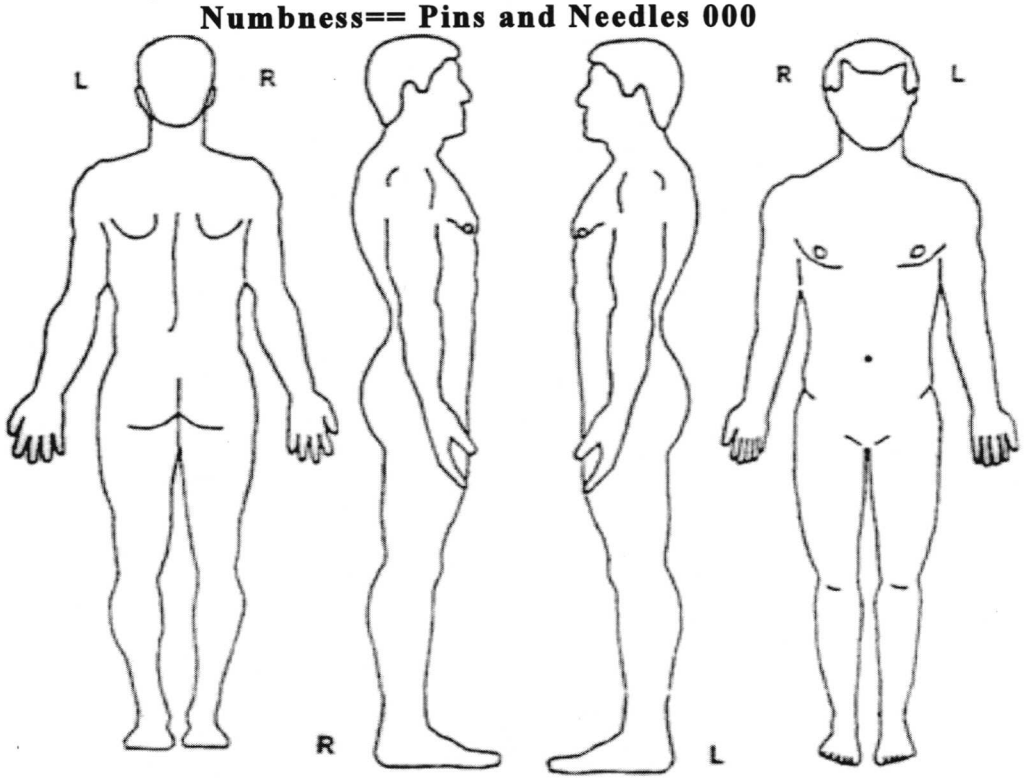
Have You Had Chiropractic Care? No/Yes; if so please indicate when and doctors name:_____

Date of Your Last Physical Examination: _____ Primary Doctor: _____

Current Complains

Use these symbols to describe the type of pain or sensations you are feeling:

Aching>>> Stabbing or Sharp pain /// Burning Pain XXX
Numbness== Pins and Needles 000



451 Hungerford Dr Suite 510 Rockville, MD 20850 (301) 738-1148

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Patient's Name: _____ Date: _____

CHIEF COMPLAINTS: _____

_____

DETAILS OF COMPLAINT

1. Did anything cause or contribute to the onset? Yes/No What? _____
2. When did the most recent episode begin? Date: _____
3. Have you sought other care for this condition? Yes/No Who? _____
4. Can you point to the exact location of your symptom(s)? .....Yes____ No____
5. How would you describe the intensity on a pain scale of 1 to 10? _____
6. Can you describe the sensation? _____ Yes ___ No_____ **(Dull, Sharp, Burning, Aching, Gnawing, Throbbing, Shooting, Constricting, Other)**
7. Has your condition been constant or intermittent through its duration? Yes/No Explain:_____
8. Does the pain radiate/travel to any part of your body? Yes/No Where? _____
9. Has there been changes in any bodily functions? Yes/No (**urination, bowel, respiration, digestion, vision, sexual, other)**
10. Has your condition been getting better, worse or about the same? _____
11. Has your condition affected your daily activities in any way? .....Yes/No How? _____
12. Is there anything that makes it worse? Yes/No What? _____
13. Have you found anything that makes it better? Yes/No What? _____
14. Have you tried store bought or home remedies? Yes/No What? _____

_____
Patient Signature

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DOCTOR'S NOTE

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Patient History

Do you have or have you ever experienced the following:					
Y	**N**	----------	**Y**	**N**	----------
		Rheumatic/Scarlett Fever			Persistent Hoarseness
		Diabetes			Persistent Nosebleeds
		Measles			Persistent Cough/Bloody Sputum/Asthma
		Rubella			Weight Changes
		Chicken Pox			Painful Urination
		Mumps			Bladder Problems
		Polio			Blood in Urine
		Shortness of Breath			Persistent Nausea/Vomiting
		Chest Pain/Pressure			Allergies
		Irregular Heart Beat/Murmur/Arrythmia			Persistent Indigestion
		Swelling of Feet			Abdominal Pain
		Leg/Arm Pain			Persistent Diarrhea
		Abnormal Bleeding			Persistent Constipation
		High Blood Pressure			Vomiting Blood
		Phlebitis			Blood in Stool
		Stroke			Yellow Jaundice/Liver Disease
		Palpitations			Kidney Disease/Infection
		Muscle Cramps/Ache while walking/at Rest			Ulcers
		Headaches			Gallstones
		Vision Problems			Clicking Jaw/TMJ
		Dizziness			Snoring
		Nubness/Paralysis			Appetite Changes
		Slurred Speech			Nighttime Urination
		Hearing Loss/Ringing			Changes in urination/Frequency per day
		Convulsions/Seizures			Changes in Bowel Function per day
		Sexual Dysfunctions			Changes in Breasts
		Memory Lapse			Arthritis/Gout
		Difficulty Swallowing			Depressions/Anxiety
		Changes in Skin (mole,wart,etc)			Smoke/Chew Tobacco…….per day
		Tuberculosis/Lung Disease/Pneumonia			Exposed to Smoke
		Cancer			Life Stress Home/Work
		Thyroid Trouble			Regular Exercise
		Veneral Infection/Syphilis/Herpes			Use of Alcohol……per day
		Hepatitis			Use of Artificial Sweeteners
		HIV/AIDS			Use of Recreational Drugs/Steroids
		Blood Transfusion			Use of Caffeine……..per day
		Painful/Swollen Joint			Sleeping Positions
		Bad Sprains/Strains			Backache
		Broken/Fractured Bones			Vitamins
		Trauma/Accidents			Other

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Patient's Name: _____ Date: _____

CURRENT MEDICATIONS

Pain	Blood Pressure	Hormones
Muscle Relaxers	Heart	Birth Control
Anti-inflammatory	Thyroid	Antidepressants
Steroids	Insulin/Diabetes	Antibiotics
Other:		

HAVE YOU EVER HAD ANY OF THE FOLLOWINGS SURGERIES?

Y	N	Date	Procedure	Y	N	Date	Procedure
			Appendix(Appendectomy)				Heart
			Hysterectomy				C-section
			Tonsils(Tonsillectomy)				Spine
			Gallbladder(Cholecystectomy)				Orthopedic
			Breast/Prostate				Hemorrhoid
			Plastic/Cosmetic/Skin				Other:

FAMILY HISTORY

Relation	Deceased	Age	State of Health	Cause of Death
Father				
Mother				
Siblings				
Spouse				
Children				

Family History of (Parents, Grandparents, Siblings, Children)

	Y	N		Y	N
Heart Disease			Cancer		
High Blood Pressure			Thyroid Disease		
Diabetes			Bleeding Disorders		
Stroke			Arthritis		
Neurologic Disorders			Other		

FOR WOMEN ONLY: Menstrual History

Date of Last Period	Excessive Flow
Length of Cycle/Regularity	Pregnancy

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Donald E. McGriff, D.C., P.C.
Advanced Chiropractic

PATIENT NAME_____ PATIENT'S INITIALS

For good and valuable consideration received, I
being the undersigned, authorize and direct you, Donald E. McGriff, D.C. any sums as may be due and owing this chiropractic office for services rendered me, both by reason of accident, or illness and/or by reason of any other bill that are due this chiropractic office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and/or accident benefits, workers' compensation benefits, or any other insurance benefits or reimbursement whatsoever for which you may be obligated to reimburse me, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said chiropractic office.

In further consideration of the above-indicated treatment, I hereby give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment, or verdict, which may be owed me as a result of the injuries or illness for which I have been treated by said office. This contract is to act as an assignment of my rights and benefits to the extent of the office's charges for services provided herein.

I, the undersigned, further hereby authorize and direct my attorney, , when settlement or judgment is reached, to pay in full the chiropractic bills rendered for all treatment and services as a result of the injuries or illness for which I have been treated by said office and any other amounts which I may owe said office at that time.

In further consideration of the treatment rendered herein, I do hereby authorize the chiropractic office to furnish you, the above-indicated party, a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and other relevant information pertaining to my treatment.

I UNDERSTAND THAT BY SIGNING THIS DOCUMENT I AM AUTHORIZING RELEASE OF REPORTS AND INFORMATION TO THE ABOVE-INDICATED PARTY, WHICH COULD INCLUDE THE RESPONSIBLE PARTY'S INSURANCE COMPANY.

Furthermore, I authorize the chiropractic office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and medical authorization.

In the event any insurance company is obligated to make payments to me upon the charges made by this office for the services rendered by refuses to make such payments, I hereby assign and transfer to this office any and all causes of action, claims, whether in law or equity, that I might have or that might exist in my favor against such company, and authorize this office to prosecute said cause of action either in my name or in the office's name and further authorize this chiropractic office to

compromise, settle or otherwise resolve any claim or cause of action in its sole discretion herein as it relates to amounts owed this doctor.

I understand that I am directly and fully responsible to said office for all medical bills submitted by them for services rendered me and this agreement is made solely for said office's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees. Said medical payments are due on demand by the office. I further understand and agree that said assignment, lien and authorization do not constitute any consideration for the office to await payment and it may demand payments from me immediately upon rendering services at its option.

This agreement is irrevocable and is binding upon the heirs, executors and legal representatives of the undersigned. Wherefore, the undersigned has hereunto set his hand this _____ day of _____, 20_____.

_____

Patient Signature

ATTORNEY ACKNOWLEDGMENT OF ASSIGNMENT, LIEN, AND AUTHORIZATION AND RELEASE OF MEDICAL RECORDS AND INFORMATION

I, _____, attorney for the above-indicated patient hereby acknowledge receipt of the above assignment and lien and agree to protect said chiropractic office pursuant to the above-indicated terms.

DATE:_____ ATTORNEY:_____

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize Advanced Chiropractic of Rockville and its licensed doctors and assistants, based on my complaints and the history I have provide, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have explained and described to my satisfaction.

Based on current findings, Practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the cost of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the practice has provided me with specific pamphlets and other literature and/or videos and the Practice doctor has answered my questions regarding the planned treatments and course of care that I will receive. The Practice doctor has also explained that my diagnosis and treatments may change during the course of care and that he will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctor will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect to any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

_____ _____

Witness Patient Printed Name

_____ _____

Date Patient Signature

Doctor's Notes:

_____

_____

_____

_____

_____

Doctor's Signature