



Grace Chiropractic
Dr. Andrea Tahmooressi
315 S Church St Suite C
Hendersonville, NC 28792
(828) 435-2377

Patient Information:

Today's Date _____	Birthday _____	Sex <input type="radio"/> Male <input type="radio"/> Female
First Name _____	Middle Name _____	Last Name _____
Married/Civil Union: <input type="radio"/> yes <input type="radio"/> no	Spouse Name: _____	# of Children: _____ Height: _____
Home # _____	Cell # _____	Weight: _____
Address _____		
Emergency Contact and Relation _____		Emergency Phone _____
Email _____		
Occupation _____	Employer _____	Student? <input type="radio"/> Full time <input type="radio"/> Part Time

Reason for this Visit:

Describe the reason for this visit? _____

When did this concern begin? _____ Has this concern: Gotten Worse Stayed Constant Come and Gone

Does this concern interfere with: Work Sleep Daily Routine Other Activities _____

Has this concern occurred before? Yes No Briefly Explain: _____

Have you seen other doctor's for this concern? Yes No Doctor's name: _____

Type of Treatment: _____

Have you been adjusted by a chiropractor before? Yes No If yes, Why? _____

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

Personal Incident History:

Broken Bones:	Yes <input type="radio"/> No <input type="radio"/>	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Sprains/Strains:	Yes <input type="radio"/> No <input type="radio"/>	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Hospitalized:	Yes <input type="radio"/> No <input type="radio"/>	Explain:	_____	
Surgery:	Yes <input type="radio"/> No <input type="radio"/>	Explain:	_____	
Auto Accident:	Yes <input type="radio"/> No <input type="radio"/>	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Struck Unconscious:	Yes <input type="radio"/> No <input type="radio"/>	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain: _____
Eating Disorder:	Yes <input type="radio"/> No <input type="radio"/>	Explain:	_____	
Stroke:	Yes <input type="radio"/> No <input type="radio"/>	Explain:	_____	



Health Checklist:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney Infection	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Swelling of Ankles	<input type="checkbox"/> Polio	<input type="checkbox"/> Headache
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Depression	<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Cramps
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Nosebleed
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Spinal Curvatures	<input type="checkbox"/> Cancer
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Eye Pain or Difficulties		

For Women Only:

Are you taking birth control?	<input type="radio"/> Yes <input type="radio"/> No	Do you have breast implants?	<input type="radio"/> Yes <input type="radio"/> No
Do you experience painful periods?	<input type="radio"/> Yes <input type="radio"/> No	Do you have excessive menstruation?	<input type="radio"/> Yes <input type="radio"/> No
Do you have irregular cycles?	<input type="radio"/> Yes <input type="radio"/> No	Do you have hot flashes?	<input type="radio"/> Yes <input type="radio"/> No
Are you pregnant?	_____	If so, what is your due date?	_____

Family Health History:

Does anyone in your immediate family (parents, grandparents or siblings) have a history of cancer, diabetes, hypertension, strokes or other serious illnesses? If so please list their relationship to you as well as the condition.

EHR Information:

Current Medications And Dosage _____

Medication Allergies _____

Smoking Status: never smoked tobacco ex-smoker current someday smoker current every day smoker

I choose to decline receipt of my clinical summary after every visit



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I certify that I'm the patient or legal guardian listed above. I have read/understand and included information and certify it to be true to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and it's staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date _____

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Grace Chiropractic as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

Missed Appointment Policy: Our policy is to charge **\$25.00** after **one** missed appointment not cancelled at least **4 hours in advance**. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment.**

Signature _____ Date _____

Printed Name _____



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HIPAA Notice of Privacy Practices

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Right to File a Complaint

You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice’s Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice’s Privacy Officer as follows:

Name: **Dr. Andrea Tahmooressi**

Address: **315 S Church Street Suite C Hendersonville, NC 28792**

Telephone No.: **(828) 435-2377**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. Grace Chiropractic reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Signature _____ Date _____

Printed Name _____



Informed Consent Form

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign. A copy will be provided to you upon request.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- muscle strength testing
- basic neurological testing
- postural analysis
- electrical stimulation
- Active Release Techniques (ART) and Instrument Assisted Soft Tissue Mobilization

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare



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and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization or Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Andrea Tahmooressi* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient’s Name

Signature or Signature of Parent or Guardian (if a minor)

Dated: _____

Andrea Tahmooressi, D.C.

Doctor’s Name

Signature