

Groves Family Chiropractic  
NOTICE OF PRIVACY PRACTICES

**This notice describes how medical information about you may be used and disclosed and how you can get access to that information. Please review this notice carefully, and sign to acknowledge receipt of this information.**

This Practice is committed to maintaining the privacy of your protected health information (“PHI”), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice’s office. It may be necessary to take patient files to a facility where a patient is confined or to a patient’s home where the patient is to be examined or treated. If you have further questions, please contact the compliance officer, Matt Groves, D.C.

No Consent Required

The Practice may use and/or disclose your PHI for the purposes of:

1. Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice’s staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.
2. Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
3. Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice’s personnel in providing care to you.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

1. De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.
2. Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as an associate doctor, billing company or massage therapist that assists the office in submitting claims for payment to insurance companies or other payers.
3. Personal Representative -To a person who, under applicable law, has the authority to represent you in making decisions related to your health care
4. Emergency Situations:
  - (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
  - (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
5. Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

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6. Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
7. Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure; if the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm
8. Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community’s health care system.
9. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
10. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
11. Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
12. Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
13. Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
14. Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
15. Workers’ Compensation – If you are involved in a Workers’ Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers’ Compensation system.

Printed Name of Patient

Signature of Patient or Representative

Date

Relationship to Patient

**If you would like to give us permission to share your protected health information with anyone else, you may list their names below: (Optional)**

I authorize Groves Family Chiropractic to disclose my protected health information to the individuals listed above.

Printed Name of Patient

Signature of Patient or Representative

Date

Relationship to Patient



Groves Family Chiropractic  
CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on \_\_\_\_\_ by Matthew Groves, D.C., and/or other licensed doctors of chiropractic who may be employed by or engaged in practice at Groves Family Chiropractic.

I have had an opportunity to discuss with Matthew Groves, D.C. or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither 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 at the time; that it 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 as 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 procedure which he/she feels at the time, based upon the facts then known, is in my best interests. I also understand that failure to follow prescribed care plans or referrals may result in adverse outcomes. I understand that chiropractic care may not be the only type of care available for my condition, and it may not completely cure my condition. I recognize and accept that there may be some residual symptoms following a course of care.

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 possible complications which have been alleged. 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 have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

\_\_\_\_\_

Printed Name of Patient	Signature of Patient or Representative	Date
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\_\_\_\_\_  
Relationship to Patient

\_\_\_\_ Please initial here if the patient is a minor, and you authorize treatment without a parent or guardian present.



Groves Family Chiropractic  
CONFIDENTIAL PATIENT CASE HISTORY

Date \_\_\_\_\_

Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

How did you hear about Groves Family Chiropractic? \_\_\_\_\_

Primary complaint today \_\_\_\_\_

Is your condition due to an accident?  Yes  No Date of Accident \_\_\_\_\_

To whom have you made a report of your accident?  Auto Insurance  Employer  Work Comp.  
 Other Attorney's Name (if applicable) \_\_\_\_\_

What date did your symptoms appear? \_\_\_\_\_

Did your symptoms appear gradually or suddenly?  Gradually  Suddenly

What caused or contributed to the onset? \_\_\_\_\_

Have you ever had anything like this before?  Yes  No

was the outcome? \_\_\_\_\_

Type of pain  Dull  Sharp  Burning  Aching  Gnawing  Throbbing  Shooting  
 Constricting  Numbness  Tingling  Stiff  Nagging  Other \_\_\_\_\_

Rate the severity of your pain right now 0 1 2 3 4 5 6 7 8 9 10

No Pain

Worst Pain

Is the pain constant or does it come and go?  Constant (Present 75% of the day or more)  
 Episodic (Tied to a particular event or time of day)  
 Intermittent (Often unpredictable)

Is this condition progressively getting better or worse?  Better  Worse  Same

Have you found anything that makes it better? (Morning, Evening, Rest, Certain Positions)  Yes  No

Explain \_\_\_\_\_

Have you found anything that makes it worse? (Positions, Activities, Coughing, Sneezing, Straining)  Yes  No

Explain \_\_\_\_\_

Has there been a change in any bodily functions? (Urination, Respiration, Digestion, Vision, Sexual)  Yes  No

Explain \_\_\_\_\_

How has your complaint affected your daily activities?

	No Affect	Mild Affect	Mod. Affect	Severe Affect		No Affect	Mild Affect	Mod. Affect	Severe Affect
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Showering or bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning over in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking over shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you tried any store bought, prescription, or home remedies?  Yes  No

If so, how effective have they been? \_\_\_\_\_

Have you sought other professional care for this condition? (Surgery, Physical Therapy, Injections)  Yes  No

Explain \_\_\_\_\_

Where did you receive this treatment? \_\_\_\_\_

Have you had previous chiropractic care?  Yes  No When? \_\_\_\_\_

Name of Chiropractor \_\_\_\_\_ City \_\_\_\_\_

Who is your primary medical doctor? \_\_\_\_\_ Facility \_\_\_\_\_

Are there any other back or neck complaints that you would like us to address?  Yes  No

Describe \_\_\_\_\_

Date it began \_\_\_\_\_ Cause \_\_\_\_\_ Severity \_\_\_\_\_

Activities that make better \_\_\_\_\_ Worse \_\_\_\_\_

Date of last Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI \_\_\_\_\_ CT \_\_\_\_\_

List any surgical procedures and dates of each \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any automobile accidents with dates and any injuries sustained \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any falls, head injuries, broken bones, or dislocations and dates of each \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any drugs, vitamins, and herbal supplements you are now taking \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Exercise Habits       None       Moderate       Daily       Heavy

Work Activity       Standing       Sitting       Light Labor       Heavy Labor

Do you currently smoke cigarettes?       Yes  No      Packs/Day\_\_\_\_\_

Have you ever been a smoker?       Yes  No

Do you consume alcohol?       Yes  No      Drinks/Week\_\_\_\_\_

Do you consume caffeine?       Yes  No      Cups/Day\_\_\_\_\_

Are you under excessive stress?       Yes  No      Reason\_\_\_\_\_

Are you pregnant?       Yes  No      Due Date\_\_\_\_\_

Do you have any allergies       Yes  No      Describe\_\_\_\_\_

Indicate if you have any relatives with the following conditions.      M = Mom      D=Dad      S=Sibling

Arthritis      \_\_\_\_\_      Heart Trouble      \_\_\_\_\_

Asthma      \_\_\_\_\_      High Blood Pressure      \_\_\_\_\_

Autism      \_\_\_\_\_      Kidney Problems      \_\_\_\_\_

Bi-Polar Disorder      \_\_\_\_\_      Liver Problems      \_\_\_\_\_

Cancer      \_\_\_\_\_      Lung Problems      \_\_\_\_\_

Diabetes      \_\_\_\_\_      Migraine      \_\_\_\_\_

Digestive Problems      \_\_\_\_\_      Obesity      \_\_\_\_\_

Ear Infections      \_\_\_\_\_      Osteoporosis      \_\_\_\_\_

Emphysema      \_\_\_\_\_      Scoliosis      \_\_\_\_\_

Epilepsy      \_\_\_\_\_      Seizures      \_\_\_\_\_

Gall Stones      \_\_\_\_\_      Stomach Problems      \_\_\_\_\_

Headaches      \_\_\_\_\_      Thyroid Problems      \_\_\_\_\_

Review of Systems: Please check the symptoms you currently have.

**HEAD**

- Headache
  - Entire head
  - Back of head
  - Migraine
  - Temples
  - Forehead
- Head feels too heavy
- Light bothers eyes
- Loss of hearing
- Pain in ears
- Ringing or buzzing in ears
- Loss of smell or taste
- Dizziness
- Loss of balance
- Ear infections
- Frequent cold/flu
- Sleep apnea

**ARMS AND HANDS**

- Pain in upper arm L/R
- Pain in forearm L/R
- Burning pain in arms
- Pain in hand L/R
- Pain in fingers
- Burning pain in fingers
- Loss of grip strength
- Loss of feeling (goes to sleep)
  - Fingers
  - Hands
  - Arms
- Hands are cold
- Finger joints swollen
- Finger joints sore

**NECK**

- Pain in neck
- Grating sounds in neck
- Neck feels out of place
- Burning pain on movement
- Stiff neck
- Muscle spasm
- Jaw problems

**ABDOMEN**

- Nervous stomach
- Eating disorder
- Nausea
- Gas
- Constipation
- Diarrhea
- Heartburn
- Irritable bowel
- Frequent urination
- Difficulty urinating
- Skin problems
- Kidney problems
- Liver problems
- Menstrual problems
- Pelvic problems

**CHEST**

- Chest pain
- Shortness of breath
- Pain around ribs
- Heart problems

**MID BACK**

- Mid back pain
- Pain between shoulders
- Muscle spasm
- Scoliosis

**SHOULDERS**

- Tension in shoulders
- Pain in shoulder joint L/R
- Burning pain on movement L/R
- Cannot raise arm L/R
  - Above head
  - Above shoulder

**LOW BACK**

- Low Back pain
- Muscle spasm

**HIPS, KNEES, LEGS AND FEET**

- Pain in buttocks L/R
- Pain in hip joint L/R
- Knee pain L/R
- Knee joint pops L/R
- Pain down leg L/R
- Numbness L/R
  - Leg L/R
- Foot L/R
  - Toes L/R
- Leg cramps L/R
- feet feel cold
- Painful toe joints L/R
- Cramps in foot L/R
- Swollen ankles L/R
- Difficulty Walking

If there are any additional health issues that you currently have, please list them here \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_