Gremmels Chiropractic Center, Inc. **(205) 854-3008**

Dr. Troy Lofton, D. C. 1705 Centerpoint Pkwy.
Birmingham, AL. 35215

DATE: _____

PATIENT DATA

FIRST NAME:_____ MI: _____ LAST NAME: _____

BIRTH DATE: _____ AGE: _____ SOCIAL SECURITY #: _____ MARITAL STATUS: _____

SPOUSE'S NAME: _____

HOW DID YOU HEAR ABOUT US? _____-

MAILING ADDRESS

ADDRESS:_____CITY:_____ STATE: _____ ZIP:_____

EMAIL ADDRESS: _____ **YOUR EMAIL WILL NOT BE SHARED **

HOME #: _____ CELL #: _____ WORK #: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ CONTACT #: _____

CURRENT COMPLAINTS

NATURE OF INJURY: **o AUTOMOBILE o WORK o OTHER** **DATE OF INJURY: _____**

HAVE YOU EVER HAD SAME CONDITION o NO o YES IF YES, WHEN : _____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE o NO o YES IF YES, WHEN : _____

LIST OF OTHER PRACTITIONERS SEEN FOR THIS INJURY/ CONDITION: _____

INSURANCE INFORMATION

NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____ PHONE: _____

DO YOU HAVE HEALTH INSURANCE o NO o YES NAME OF COMPANY: _____

*** IF INJURY IS DUE TO AUTO ACCIDENT or WORKMAN'S COMP PLEASE PROVIDE INFORMATION ***

INSURANCE COMPANY _____ CONTACT PERSON _____

PHONE #: _____ CLAIM #_____

ATTORNEY: _____ PHONE: _____

SIGNATURES

NAME OF THE INSURED: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____ DATE _____

MEDICAL HISTORY

HAVE YOU BEEN TREATED FOR ANY CONDITIONS IN THE LAST YEAR o NO o YES

IF YES, PLEASE DESCRIBE _____

DATE OF LAST PHYSICAL EXAM _____ IS THERE A CHANCE YOU ARE PREGNANT o NO o YES

HAVE YOU HAD X-RAYS TAKEN oNO oYES IF YES, WHERE _____

HAVE YOU EVER:	***NO***	***YES***	***BRIEFLY EXPLAIN***
BROKEN BONES	o	o	
BEEN HOSPITALIZED	o	o	
BEEN IN AN AUTO ACCIDENT	o	o	
HAD SPRAINS/STRAINS	o	o	
BEEN STRUCK UNCONSCIOUS	o	o	
HAD SURGERY	o	o	
HIV/ STD	o	o	

	NO	***YES***
DO YOU EXPERIENCE PAIN EVERY DAY	o	o
DO YOUR SYMPTOMS INTERFERE WITH DAILY LIFE	o	o
DOES PAIN WAKE YOU UP AT NIGHT	o	o
ARE YOUR SYMPTOMS WORSE DURING CERTAIN TIMES OF THE DAY	o	o
DO CHANGES IN WEATHER AFFECT YOUR SYMPTOMS	o	o
DO YOU WEAR ORTHOTICS	o	o
DO YOU TAKE VITAMIN SUPPLEMENTS	o	o

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS _____

_____

_____

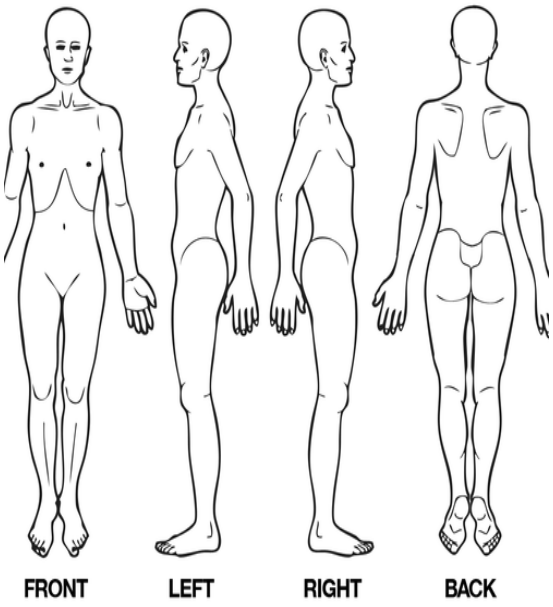
HABITS	***NONE***	***LIGHT***	***MODERATE***	***HEAVY***	***HOW OFTEN / HOW MANY***
ALCOHOL	o	o	o	o	
COFFEE	o	o	o	o	
TOBACCO	o	o	o	o	
DRUGS	o	o	o	o	
EXERCISE	o	o	o	o	
SLEEP	o	o	o	o	
APPETITE	o	o	o	o	
SOFT DRINKS	o	o	o	o	
WATER	o	o	o	o	
SALTY FOODS	o	o	o	o	
SUGARY FOODS	o	o	o	o	
ARTIFICIAL SWEETENERS	o	o	o	o	

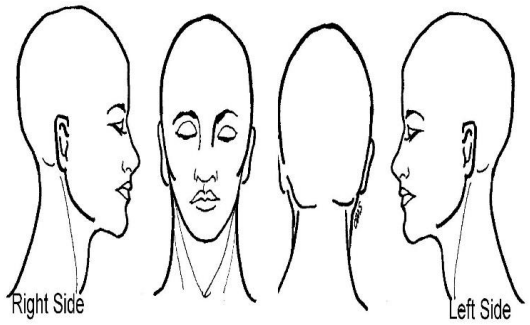
HAVE YOU EVER SUFFERED FROM:

- o ALCOHOLISM
- o ALLERGIES
- o ANEMIA
- o ARTERIOSCLEROSIS
- o ARTHRITIS
- o ASTHMA
- o BACK PAIN
- o BREAST LUMP
- o CANCER
- o CHEST PAIN / CONDITIONS
- o COLD EXTREMITIES
- o CONSTIPATION
- o DEPRESSION
- o DIABETES
- o DIZZINESS
- o EARS RINGING
- o FATIGUE
- o FREQUENT URINATION
- o HEADACHE
- o HIGH BLOOD PRESSURE
- o IRREGULAR HEART BEAT
- o LOSS OF MEMORY
- o LOSS OF BALANCE
- o NECK PAIN OR STIFFNESS
- o NOSEBLEEDS
- o PACEMAKER
- o POLIO
- o PROSTATE TROUBLE
- o SHORTNESS OF BREATH
- o STROKE
- o SWELLING OF ANKLES
- o SWOLLEN JOINTS
- o THYROID CONDITION
- o TUBERCULOSIS
- o ULCERS
- o VARICOSE VEINS
- o VENEREAL DISEASE
- o OTHER _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A= Ache	**O**= Other
B= Burning	**P**=Pins & Needles
N= Numbness	**S**= Stabbing





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New Patient Intake Form
Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/ or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the physician at Gremmels Chiropractic Center, Inc. and / or other licensed Physicians of Chiropractic who may treat me now or in the future at the office. I have had an opportunity to discuss with the Doctor and / or with office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risk to treatment; including, but not limited to: fractures, disc injuries, stroke (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

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, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

Date:_____/_____/_____

To be completed by patient's representative, if necessary, (e.g., if the patient is a minor or is physically or mentally incapacitated)

_____
Print Name of Representative

_____
Signature of Representative

Date:_____/_____/_____

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PATIENT MEDICATIONS AND ALLERGIES

PATIENT'S NAME: _____ **DATE:** _____

ARE YOU TAKING ANY MEDICATION? o Yes o No

*IF YES PLEASE LIST BELOW

MEDICATIONS:

DO YOU HAVE ALLERGIES? o Yes o No

*IF YES PLEASE LIST BELOW

DO YOU SMOKE? o Yes o No

If YES, how often_____