Dr. Jana Joshu Grimm, DC Intake and Consent Forms

Name ________________________________ Age _______ DOB ________ Blood Type ________
Address ____
Phone______________________________ Email ______________________________________
Referred by: ________________________ Occupation: ________________________________
Height ______ Weight _______ Single ☐ Married ☐ Widowed ☐ Children/ages ___________

FEMALES ONLY:
Infertility ☐ Pregnant ☐ Breast-feeding ☐ Peri-menopause ☐ Menopause ☐ Hysterectomy ☐
Birth control ☐ HRT ☐ If yes to either, what kind ______________________________________
Problems w/cycles/hormones ____

EVERYONE:
Reason for visit ____
Date symptoms began ___________________________ Gradually ☐ Suddenly ☐ Over time ☐
Other treatments you've tried for this____

History of Antibiotic/Rx drug use ____

Surgeries/Hospitalizations & approximate date/year ____________________________________
____

List ALL allergies ____
____

Have you had any dif culties with the following organs/systems? (Check all that apply)
Allergies/Sinus ☐ Cardio/Heart/Blood/Gums ☐ Digestive/Bowel ☐ Eyes/Ears/Nose/Throat ☐
Hair/Skin/Nails ☐ Hepatic/Liver/Gallbladder ☐ Immune ☐ Lymphatic/Veins Muscular/Joint ☐
Neurological/Brain ☐ Pulmonary/Lungs ☐ Reproductive ☐ Skeletal/Spinal ☐ Urinary/Kidney ☐

Do you drink: Alcohol ☐ Soda ☐ Coffee ☐ Energy Drinks ☐ **Smoke** _____ packs/day

Exercise ☐ Type/Frequency ____

Do you fall asleep easy ☐ **Stay asleep** ☐ **Wake up rested** ☐

Number of Bowel Movements _______ /day **or** _______ /week
Are they: daily ☐ solid ☐ hard ☐ soft ☐ loose ☐ diarrhea ☐ bloody ☐ incomplete ☐

Rate your stress: **No Stress** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Totally Overwhelmed**

What are your health goals or concerns (physical, spiritual, emotional)?
____
____
____

I acknowledge this information is true and correct ______________________________ Signature

INFORMED CONSENT - Dr. Jana Joshu Grimm, DC

I hereby request and consent to the performance of Nutritional Consulting and Muscle Testing within the scope of Chiropractic care, Chiropractic adjustments and/or any other Chiropractic procedures, including various modes of physiotherapy, on me (or the patient named below, for whom I am legally responsible) by the Doctor or any licensed practitioner affiliated with Dr. Jana Joshu Grimm, DC.

I understand that, as in the practice of medicine, in the practice of Chiropractic care there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications.

I wish to rely on the Doctor to exercise judgment during the course of the procedure, which the Doctor feels at the time, based on facts then known, is in my best interest. I have read, or have had read to me, the above consent.

By signing below I agree to the above and allow Dr. Jana Joshu Grimm, DC or any licensed practitioner affiliated with Dr. Jana Joshu Grimm, DC to perform such care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____
Print name (self)

____ _______________
Signature Date

____
Printed Minor’s name

____ _______________
Parent/Legal Guardian Signature Date

Dr. Jana Joshu Grimm, DC
30448 Rancho Viejo Rd Suite #174
San Juan Capistrano, CA 92675

Acknowledgement of Receipt of Notice of Privacy Practice

I certify that I have read or reviewed **Dr. Jana Joshu Grimm's** Notice of Privacy Practices as displayed in the office and/or at http://www.drjana.com/privacy-policy.html. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Dr. Jana Joshu Grimm, DC** healthcare operations. The Notice of Privacy Practices also describes my rights and **Dr. Jana Joshu Grimm, DC's** duties with respect to my protected health information.

Dr. Jana Joshu Grimm, DC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent to me by email or asking for one at the time of my next appointment.

____ ____________________
Signature of Patient Date
(or personal representative)

____
Printed Name of Patient

____
Printed Name of Personal Representative

____
Legal Relationship of Personal Representative