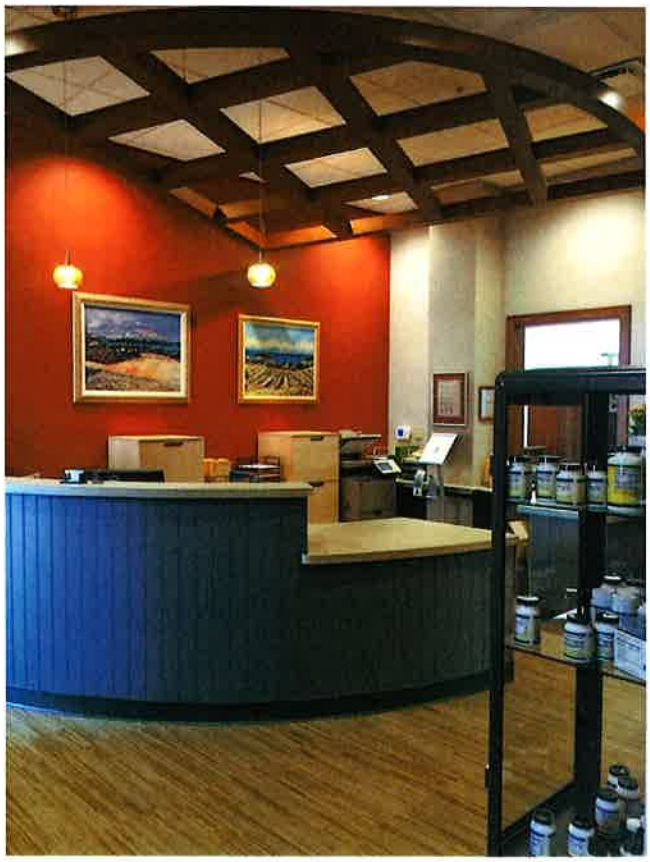
David N Grimshaw, DO

Integrative Neuromusculoskeletal Medicine

WELCOME



Introductory Patient Information

David N Grimshaw, DO, PLC

1106 N Cedar St Suite 200B

Lansing, MI 48906

Phone: (517)492-4818

Fax: (517)492-4896

www.oldtowndoc.com

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Web: http://www.oldtowndoc.com

Greetings and ***Welcome*** to our practice. I've enclosed a history form that we will review together at our first visit. Please complete it to the best of your ability. You are welcome to add what you may have already prepared to express your concerns and goals for our work together. I will listen to your concerns and history as you walk me through it, working to understand you and the context of your situation as well. I see my relationship with patients as a ***Partnership for Health.***

If you have records, reports, x-ray, MRI, or other studies that pertain to your concerns, please bring these things along with you so that we can review them together. I will take the time and effort to read and assimilate this information.

A typical adult new patient appointment can last 1.5 to 2 hours. It will be a comprehensive visit that begins with a review of your history, moves to an exam and...if appropriate, an Osteopathic Manual Medicine treatment. It usually concludes with a summary of findings and together we form a plan of treatment.

For children and adolescents, please allow 60 to 90 minutes. We are baby and breast feeding friendly and have a child friendly area within the suite. If the child has been through a protracted illness or medical experiences that have been difficult, if possible, please bring two adults so that there may be a time for Dr. G to interview a parent without the child present. It can be upsetting to a child to hear that story over and over again.

For musicians, dancers, and actors with Performance Related Injuries: Please bring your instrument and/or equipment that relates to the playing related injury with you. We do have a piano in the office.

For First Line Therapy Clients, I coordinate with my Lifestyle Educator, Beth Grimshaw. We like to meet with you together for the first appointment. We welcome and encourage significant others and additional family members to come with the identified patient. That first visit usually lasts 1.5 to 2 hours. We do a comprehensive review of your concerns, history, lab reports, and any other information you would like to share. You will also receive an exam, a Bioimpedance Analysis, and a detailed explanation of the program. Engaging with you in the process of Lifestyle Change, we will work to help you cultivate change in the direction you seek. The four main elements of the program are: Nutrition, Exercise, Sleep, and Stress Management.

I look forward to meeting you.

David N. Grimshaw, DO
Clinical Associate Professor, Michigan State University College of Osteopathic Medicine
Adjunct Associate Professor, Michigan State University College of Music
Board Certifications: Family Medicine, Neuromusculoskeletal Medicine, Cranial Osteopathy

GENERAL INFORMATION----------

Name: _____ Preferred name_____

Date of Birth: _____

Identify As: ☐ Male ☐ Female ☐ Other

Genetic Background: ☐ African ☐ Asian ☐ European ☐ Native American
☐ Ashkenazi ☐ Middle Eastern ☐ Mediterranean ☐ Other _____

Highest Education Level: ☐ High School ☐ Under-Graduate ☐ Post-Graduate

Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Type of work you do: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Primary Care Physician: _____

Phone Number: _____ Fax Number: _____

Primary Insurance: _____

Policy Holder's Name: _____ D.O.B _____

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with me? _____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment	Excellent	Good	Fair

PAST MEDICAL HISTORY

Diseases/Diagnoses/Conditions

Please indicate if you have any of these conditions, whether it is a past or current condition, when it occurred or began, and how it is going now.

GASTROINTESTINAL	Past	Current	Onset and Course
GERD/Reflux Esophagitis			
Irritable Bowel Syndrome			
Crohn's Disease			
Celiac Disease			
Ulcerative Colitis			
Gastritis or Peptic Ulcer			
Bleeding			
Other			
RESPIRATORY			
Asthma			
COPD/Emphysema			
Recurring Bronchitis			
Pneumonia			
Frequent Sinus Infections			
Frequent Colds			
Other			
CARDIOVASCULAR			
Heart Attack			
Other Heart Disease			
Stroke or Transient Ischemic Attack			
Elevated Cholesterol			
Arrhythmia (Irregular Heart Rhythm)			
High Blood Pressure			
Other			
METABOLIC/ENDOCRINE			
Diabetes Type 1			
Diabetes Type 2			
Hypoglycemia			
Metabolic Syndrome			
Hypothyroidism			
Hyperthyroidism			
Polycystic Ovary Syndrome			
Infertility			
Weight Loss or Gain			
Eating Disorder			
Other			
GENITOURINARY			
Kidney Stones			
Interstitial Cystitis			
Frequent Urinary Tract Infections			
Frequent Yeast Infections			
Pelvic Pain			
Other			

MUSCULOSKELETAL	Past	Current	Onset and Course
Osteoarthritis	____	____	_____
Fibromyalgia	____	____	_____
Chronic Back or Neck Pain	____	____	_____
Chronic Facial or Jaw Pain	____	____	_____
Muscular Dystrophy	____	____	_____

INFLAMMATORY/IMMUNE			
Chronic Fatigue Syndrome	____	____	_____
Rheumatoid Arthritis	____	____	_____
Systemic Lupus Erythematosis	____	____	_____
Chronic or Severe Infectious Disease	____	____	_____
AIDS	____	____	_____
Poor Immune Function	____	____	_____
Food or Environmental Allergies	____	____	_____
Multiple Chemical Sensitivities	____	____	_____
Atopic Dermatitis/Eczema	____	____	_____
Other	____	____	_____

CANCER

Have you ever had cancer? If so, which kind or kinds? _____

NEUROLOGICAL			
Depression or Anxiety Disorder	____	____	_____
Bipolar Disorder	____	____	_____
Schizophrenia	____	____	_____
Headaches and/or Migraine	____	____	_____
ADD/ADHD	____	____	_____
Memory Problems	____	____	_____
Parkinson's Disease	____	____	_____
Multiple Sclerosis	____	____	_____
Seizures/Epilepsy	____	____	_____
Autism	____	____	_____
Other	____	____	_____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ EBT Heart Scan _____
- ☐ EKG _____
- ☐ Hemoccult Test _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

SURGERIES

Check box if yes and provide date of service

- ☐ Appendectomy _____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement _____
- ☐ Heart Surgery _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Spine Surgery _____
- ☐ Other _____

HOSPITALIZATIONS None_____

Date:	Reason:

INJURIES

- ☐ Back Injury
- ☐ Neck Injury
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Loss of teeth
- ☐ Involving motor vehicles
- ☐ Bicycle or pedestrian
- ☐ Spine Injury
- ☐ Injury to your limbs
- ☐ Other trauma _____
- ☐ Repetitive Stresses/Strains
- ☐ Torn muscles/tendons/ligaments
- ☐ Wounds/lacerations
- ☐ Falls

GYNECOLOGIC HISTORY (for women only)

Pregnancies _____Caesarian _____ Miscarriage_____ Vaginal Deliveries _____ Living Children _____

Age at First Period? _____ Frequency of menses? _____ Length? _____ Pain? _____

Has your period ever skipped? _____ For how long? _____ Last Menstrual Period? _____

MEN'S HISTORY (for men only)

Have you had a PSA done?_____ PSA elevated? _____ Prostate Enlargement ?_____Prostate Infection?_____

Change in Libido?_____ Impotence?_____ Difficulty Obtaining an Erection?_____

Difficulty Maintaining an Erection?_____ Nocturia? (urination at night)_____ How many times at night?_____

Urgency/Hesitancy/Change in Urinary Stream or Loss of Control of Urine?_____

GI HISTORY

Foreign Travel ☐ Yes ☐ No Where? _____

Wilderness Camping ☐ Yes ☐ No Where? _____

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

PATIENT BIRTH HISTORY

☐ Term ☐ Premature

Pregnancy Complications: _____

Birth Complications: _____

☐ Breast Fed How long? _____ ☐ Bottle Fed

Age at introduction of: Solid Foods:_____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No

DENTAL HISTORY----------

☐ Silver Mercury Fillings? How Many? _____ ☐ Orthodontics? At what age? _____

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums ☐ Gingivitis

☐ Problems with Chewing? ☐ Do you floss regularly? _____

MEDICATIONS----------

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc)? ☐ Yes ☐ No

Frequent antibiotics ☐ Yes ☐ No

Long term antibiotics ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No

Use of oral contraceptives ☐ Yes ☐ No

FAMILY HISTORY----------

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Disease												
Celiac Disease												
Asthma												
Eczema/ Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY----------

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No Describe: _____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan

☐ Specific Program for Weight Loss/Maintenance Type: _____

Height (feet/inches): _____ Current Weight: _____

Do you avoid any particular foods? ☐ Yes ☐ No If yes, types and reason: _____

_____

If you could eat only a few foods a week, what would they be? _____

_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? _____

Do you read food labels? ☐ Yes ☐ No Do you cook? ☐ Yes ☐ No If no, who does the cooking? _____

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% of meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance on convenient items
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: _____

_____

_____

_____

_____

SMOKING

Currently smoking? ☐ Yes ☐ No If yes, how many years? _____ Packs per day: _____

Previous smoking: How many years? _____ Packs per day: _____

Second hand smoke exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10

Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None

OTHER SUBSTANCES

Caffeine Intake: ☐ Yes ☐ No Cups of coffee/tea per day ☐ 1 ☐ 2-4 ☐ >4

Caffeinated Sodas or Diet Sodas Intake: ☐ Yes ☐ No

Are you currently using any recreational drugs? ☐ Yes ☐ No If yes, type: _____

EXERCISE

Current Exercise Program: *(List type of activity, number of sessions per week and duration)*

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, walking, etc.)			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

List problems that limit activity: _____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: _____

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No Have you ever experienced major losses in your life? ☐ Yes ☐ No

STRESS/COPING

Have you ever sought counseling? ☐ Yes ☐ No

Daily Stressors: Rate on a scale of 1-10

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No How often? _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

SLEEP/REST

Average number of hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have trouble falling or staying asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

ROLES/RELATIONSHIPS

☐ ☐ ☐ ☐ ☐

Marital Status: Single Married Divorced Long term partnership Widow

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Who lives in your household? _____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other _____

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT ----------

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No

Do you have adverse reactions to chemicals, odors or environments? ☐ Yes ☐ No

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Do you have a history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Mold ☐ Air Pollution

Do you have pets or farm animals? ☐ Yes ☐ No

SYMPTOM REVIEW ----------

Please check all current symptoms occurring or present in the past 6 months

GENERAL

- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS

- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Eye Pain
- ☐ Hearing Problems
- ☐ Headache
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems

MUSCULOSKELETAL

- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Twitches – around eyes
- ☐ Muscle Twitches – arms or legs
- ☐ Muscle Weakness
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES

- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

DIFFICULTIES WITH

- ☐ Concentration
- ☐ Balance
- ☐ Thinking
- ☐ Judgment
- ☐ Speech
- ☐ Memory
- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Phobias
- ☐ Panic Attacks
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Cravings
- ☐ Sweet Cravings
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating
- ☐ Burping
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/ Poor Chewing
- ☐ Diarrhea
- ☐ Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Food "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Sores Inside Your Mouth
- ☐ Vomiting
- ☐ Liver Disease/Jaundice
- ☐ Sore Tongue
- ☐ Change in Appearance of Stool

SKIN PROBLEMS

- ☐ Acne
- ☐ Athlete's Foot
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Blotches /Pigment Changes
- ☐ Moles w/ Color/Size Change
- ☐ Oily Skin
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Hair Loss
- ☐ Itching Skin Where? _____
  _____
- ☐ Dryness Where? _____
  _____
- ☐ Any cracking?
- ☐ Any peeling?
- ☐ Change in Hair Distribution or Texture/
- ☐ Any Dandruff?
- ☐ Enlarged or Tender Lymph Nodes?
- ☐ Changes in Finger or Toenails?

RESPIRATORY

- ☐ Persistent Cough
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing

CARDIOVASCULAR

- ☐ Angina/Chest Pain
- ☐ Breathlessness
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Take several nutrition supplements each day..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Keep a record of everything you eat each day..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Modify your lifestyle (e.g., work demands, sleep habits)..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Practice a relaxation technique..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Engage in regular exercise..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Have periodic lab tests to assess your progress..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

_____

_____

Thank you for taking the time to fill this form. I will go over it with you at our first appointment.

Please read the following paragraphs and sign and date each area below.

RELEASE OF INFORMATION

I hereby authorize David N. Grimshaw, DO PLC to release medical and financial information pertaining to services rendered to the third party insurance carrier(s) for charges incurred in my treatment.

_____ _____

Signature **Date**

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that the charges may exceed the benefits payable or may not be a covered benefit under my present insurance plan. I agree to accept financial responsibility for payment in full or for any balance remaining for the services rendered.

_____ _____

Signature **Date**

CONSENT FOR TREATMENT

I hereby consent to receive and participate in treatment/testing with David N. Grimshaw, DO PLC.

_____ _____

Signature **Date**

David N. Grimshaw, D.O., PLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, David N. Grimshaw, D.O., PLC may use and disclose protected health information about me to carry out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

With my consent, David N. Grimshaw, D.O., PLC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, David N. Grimshaw, D.O., PLC may mail to my home or other designated location any items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, such as appointment reminder cards and patient statements.

With my consent, David N. Grimshaw, D.O., PLC may e-mail to my home or other designated location any items that assist the practice in carrying out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

By signing this form, I am consenting to David N. Grimshaw, D.O., PLC's use and disclosure of my protected health information to carry out TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, David N. Grimshaw, D.O., PLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

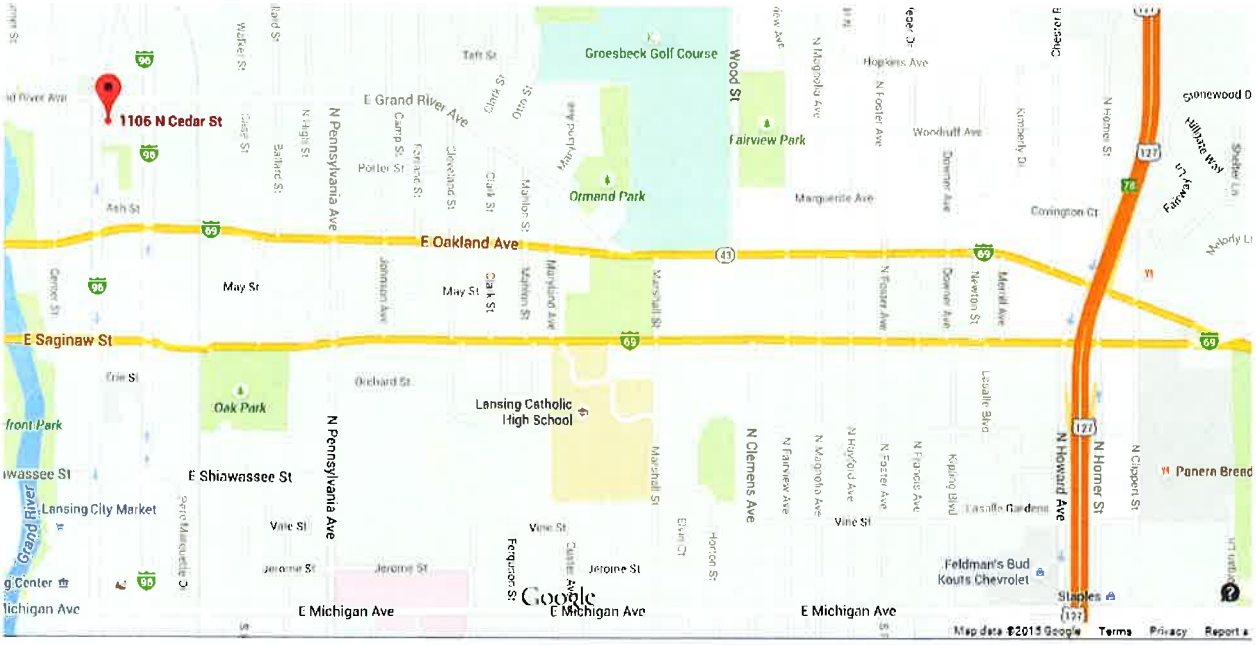
Date

Print Name of Patient or Legal Guardian

David N Grimshaw, DO, PLC

1106 N Cedar St. Suite 200B

Lansing, MI 48906



From US-127:

Take exit 78 (Grand River/Oakland/Saginaw). Head west on Oakland Ave. for approximately 3 miles. Turn right onto Larch St. heading north. In approximately half a mile you will see Maple St. on the left-hand side. Make a left onto Maple St. On the right you will see the entrance to the parking lot of our building, the Medical Arts Building. Go up one flight of stairs to the second floor and enter into the waiting room area. The entrance to the office is on the right side of the waiting room. Elevators are available if needed.

If you have questions or need clarification on direction, please give our office a call at **(517) 492-4818**.

(Please note, while our address is on Cedar St, our parking lot is on Maple St. If you enter our address into your GPS, it will not take you to our parking lot, so please read the instructions above about getting to Maple St.)