DONAHUE CHIROPRACTIC

New Patient Information

Name_____ ☐ Female ☐ Male Date _____

What you prefer to be called_____ Age _____ Date of birth _____

Preferred Language: English Other_____ Race: White African American Other _____

Address _____ City _____State_____Zip_____

Home Phone _____ Cell Phone _____

Email Address _____ SS# _____

Preferred Method of Contact _____

Employer_____Occupation_____Work Phone_____

Emergency Contact_____Relation_____ Phone_____

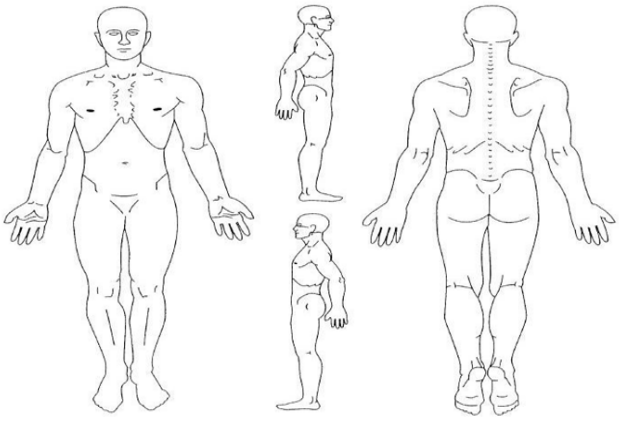
How did you hear about our office? _____

When did your condition begin?_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning

S=Sharp T=Tingling A=Dull Ache



Other Doctors seen for this condition?_____

_____

Have you had the same or similar symptoms before? ☐ Yes ☐ No

Date of prior condition_____

List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Average Pain Intensity for the last 24 hours:

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physican_____

May we forward our findings to your doctor? ☐ Yes ☐ No

Current Medications _____

_____

Allergies (Medicine, Food, Environment) _____

_____

Previous Surgeries _____

Do you have a PERSONAL history of:

☐ Cancer ☐ Diabetes ☐ Heart ☐ Disease ☐ Stroke

Other serious illnesses_____

Check all symptoms that apply to you:

☐ Headache	☐ Tingling/numbness in arms/hands	☐ Chest Pain	☐ Unexplained weight loss
☐ Neck Pain/Stiffness	☐ Tingling/numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back Pain/Stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐ Shoulder Pain	☐ Shortness of breath	☐ Fever	☐ Blood in Urine
☐ Night Pain	☐ Pain unrelieved by rest		

Other_____

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Health and History Assessment

Lifestyle history

Exercise: 0 1 2 3 4 5 6 7 days/ wk _____minutes. Type_____
What position do you sleep in: Side Stomach Back Other_____
How old is your mattress: _____yrs What type: coil spring foam water air _____
What type of pillow do you sleep on: foam memory foam fiberfill feather Other_____
Do you wear: arch supports orthotics heel lifts
Do you take; blood thinners (heparin, coumadin, warfarin), birth control pills, steroids
Do you have any family history of; rheumatoid arthritis, gout, ankylosing spondylitis, lupus, stroke

Circle all that apply below:

General

Cancer, diabetes, thyroid disease, AIDS or HIV

Fatigue, recent unexplained weight loss, decreased energy, loss of appetite, night sweats, fever or chills, recurrent infections, skin ulcers or rashes, excessive thirst

Neuromusculoskeletal

Stroke, paralysis, seizures, mental disorders, fractures, dislocations, orthopedic problems, arthritis, rheumatoid arthritis, gout, lupus, osteoporosis, scoliosis

Change in vision, smell, hearing or taste, light headedness, dizziness/ vertigo, loss of consciousness, difficulty speaking or swallowing, headaches, numbness or tingling, difficulty walking, change in mood or behavior

Cardiovascular

Pacemaker, defibrillator, high blood pressure, heart disease, irregular heart beat, heart attack, congestive heart failure, TIA, peripheral vascular disease, blood clotting or bleeding disorder, anemia

Chest pain, shortness of breath, nose bleeds, swollen ankles, redness or swelling of a limb, unusual bruising, bleeding gums, swollen lymph nodes

Respiratory

Asthma, emphysema, tuberculosis, COPD

Cough or change in cough, blood in sputum, wheezing, difficulty breathing

Digestive

Liver disease, hepatitis, ulcers, gall stones, appendicitis, pancreatitis, reflux disease

Stomach pain, pain or difficulty swallowing, indigestion, nausea, vomiting, diarrhea, constipation, bloating, excessive gas or belching, blood in stool, black stools, jaundice

Genitourinary

Kidney disease, kidney stones, prostate enlargement

Burning with urination, blood in urine, increased frequency of urination, difficulty with urination, loss of bladder or bowel control, change in menstrual bleeding

Family medical history (please list any pertinent diseases affecting your family)
Father:_____
Mother:_____
Siblings:_____
Grandparents:_____

Social history
Marital status: ☐ M ☐ S ☐ W ☐ D
Occupation_____
Do you smoke ☐ No ☐ Yes How much_____
Do you drink alcohol ☐ No ☐ Yes How much on a typical day_____

Health Insurance
Policyholder Name _____Date of Birth _____

Workers Compensation
Is your condition due to an Employment Related Injury? ☐ Yes ☐ No Have you reported it? ☐ Yes ☐ No
Date of accident _____
Supervisor _____ Supervisor # _____

Auto Accident
Is your condition due to Automobile Accident? ☐ Yes ☐ No Date of accident _____
Auto Accident Insurance Name _____ Claim # _____
Adjuster Name _____ Phone #_____
Attorney Name _____ Phone #_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

By_____
Patient's Signature

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Brennan Donahue and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the utcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Donahue Chiropractic for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____
Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct Donahue Chiropractic, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is
attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____
Date Signed _____
Witness _____