Confidential Patient Case History

Name (*First Middle Last*) _____ SSN_____ Date _____

Address_____City/State/Zip_____

Birth Date____/____/____Age_____Spouse's Name_____Number of Children_____

Home Phone_____Cell Phone_____Preferred Language _____

Email_____Referred by_____Preferred Contact Number: *Home Cell*

Occupation_____*full-time part-time* Preference for Appointment Reminders: *Email Text Message*

IN CASE OF EMERGENCY: Name/Relation_____Phone_____

Please check any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

General
__Allergies
__Dizziness
__Fainting
__Fatigue
__Fever
__Headache
__Loss of Sleep
__Nervousness/depression
__Numbness

Cardio-Vascular
__Heart Disease
__High blood pressure
__Low blood pressure
__Pain over heart
__Poor Circulation
__Pacemaker

Eyes, Ears, Nose & Throat
__Asthma
__Colds
__Earache
__Ear noises
__Eye pain
__Failing vision
__Nosebleeds
__Sore throat
__Sinus infection

Muscle & Joint
__Arthritis
__Foot Trouble
__Low back pain
__Neck pain or stiffness
__Spinal Curvature

Pain or numbness
__Shoulders
__Arms
__Elbows
__Hands
__Hips
__Legs
__Knees
__Feet
__Tailbone
__Sciatica

Gastro-Intestinal
__Constipation
__Diarrhea
__Difficult Digestion
__Gallbladder trouble
__Hemorrhoids
__Nausea

__Pain over stomach
__Vomiting
__Poor appetite

Respiratory
__Chest pain
__Chronic cough
__Difficult breathing
__Spitting up blood
__Spitting up phlegm
__Wheezing

Genito-Urinary
__Bed Wetting
__Blood in urine
__Frequent Urination
__Inability to control kidneys
__Kidney infection or stones
__Painful urination
__Prostate trouble

For Women Only
__Cramps or backache
__Hot flashes
__Irregular cycle
__Menopausal symptoms
__Painful menstruation
Are you pregnant? *Yes No*
Due Date: _____

Mental Health
__Anxiety
__Depression
__Bipolar
__Other_____

Check the following conditions you have have/had

__Alcoholism	__Cold sores	__Influenza	__Pleurisy	__STD
__Appendicitis	__Diabetes	__Measles	__Pneumonia	__Stroke
__Arteriosclerosis	__Eczema	__Miscarriage	__Polio	__Tuberculosis
__Arthritis	__Emphysema	__Multiple Sclerosis	__Rheumatic fever	__Ulcers
__Cancer	__Epilepsy	__Mumps	__Scarlet fever	__Whooping cough

Habits: Heavy/Moderate/Light/Never/Former

Alcohol _____ Coffee_____ Tobacco_____ Drugs_____ Exercise_____

Please complete back page

Please Print and Complete the Following

What is your major complaint?

Is your complaint a result of a work injury or Car Accident: **Yes No if yes specify**:

What caused your complaint?

When did your complaint start?

Severity of your pain: (no pain☺) **1 2 3 4 5 6 7 8 9 10** (severe☹)

How would you describe your symptoms (circle any that applies): **Dull Ache Pressure Stiff Burning Sharp Hot Numb Tingle Other:**

Do you have any pain that travels into your arms or legs? **Yes No**. If yes please specify

What activities aggravate your condition?

What relieves your condition/symptom?

Have you had this or similar conditions in the past? **Yes No If yes specify:**

Circle any that apply: Is this condition getting progressively worse? **Yes No Constant Comes and goes**

Doctor's Notes (office use only)

Have you been in an auto accident: **Past Year Past Five Years Over Five Years Never**

Any past traumas and/or broken bones? **Yes No if yes specify:**

Is your complaint condition interfering with your **Work Sleep Daily routine Other**

List all surgical operations and years:

Do you have a pacemaker or surgical implanted device? **Yes No if yes specific**

Are you currently taking any medications, vitamins, or mineral supplements? **Yes No If yes specify**

What position do you sleep in (circle any that applies): **Back Side Stomach**

How many pillows do you sleep with (or behind your head)?

Family Health Information: Any Family members have similar neck or back problems? YES or NO

Name	Relation	Past and Present Health Problems

Name of family physician_____City_____Phone _____

Doctors Signature: _____ Date: _____

Doctor's Notes (office use only)

Donay Life and Wellness Center
Financial Policy

At Donay Life and Wellness Center, our motto is “Relief First, Wellness Always.” Our recommendations for care are based on a desire to see you get well and stay well with wellness care. Chiropractic care is covered under many insurance plans. Most of our patients have health or accident insurance that falls under one of the plans discussed in our Financial Policy brochure. Regardless of your coverage, we will suggest the chiropractic care most appropriate for your condition.

Please initial the following if applicable:

_____I have received and read my copy of Donay Chiropractic’s Financial Policy. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Donay Chiropractic Center and my insurance company. I request that Donay Chiropractic Center prepare the customary forms at no charge so that I can utilize my insurance benefits. I understand that I am financially responsible for any service that my insurance company may deny as not medically necessary or any other non-covered charges.

_____I authorize DLWC to release any medical information to complete any customary reports and forms to assist in collection from my insurance company. I authorize payment of medical benefits to be payable to Donay Chiropractic Center.

If you are not the primary policy holder:

_____I give permission to Donay Chiropractic Center to speak to the guarantor on my insurance policy regarding my diagnosis, care plan, and/or financial arrangement.

Or:

_____ I do not give permission to Donay Chiropractic Center to speak to the guarantor on my insurance policy regarding my diagnosis, care plan, and/or financial arrangement.

DLWC has permission to discuss my care and insurance with the following:

Name: _____ Relationship:_____Phone: _____

Patient Signature: _____ Patient Parent or Legal Guardian_____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office us submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies requite for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented .
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. As a way of showing our appreciation, if you refer a patient to our office, your name may be added to our referral board which is located in the patient reception area. You agree to allow this to be done or will notify us upon the referral.
9. I understand that upon entering this facility, my name will be signed on a sign-in sheet that will remain in the reception area of the office. I also realize that any person entering this office may rad my name on the sign-in sheet as a patient.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name Date

Informed Consent for Chiropractic Treatment

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation and physical therapy services.

- Some patients may experience short term soreness, stiffness and occasionally an aggravation of symptoms. Although rare, strains, sprains and rib fractures have been reported as a result of manual therapy techniques.
- The possibility of adverse reaction due to ancillary procedures is also considered "rare".
- Other rare complications include cervical myelopathy, disc and vertebral injuries.
- The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by exam procedures.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications and surgical procedures given for the same treatments.
Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and accelerates degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.
Common alternatives to chiropractic treatments include medications, physical therapy, other medical and surgery provided by physicians and surgeons.
By signing this Informed Consent, I understand and am informed that some risks are associated with chiropractic treatment. You have the opportunity to discuss further with your doctor of chiropractic by verbally requesting this to the office staff or the doctor themselves.

- If you have a metal implant including pacemakers, defibrillator, stimulator, surgical and non-surgical metal, please make your doctor aware and complete the section on your intake form.
- If you are pregnant, the use of x-ray may pose a risk, please make your doctor aware and complete the section on your intake form.

Patient printed name: _____

Patient or legal guardian signature: _____

Witness: _____ Date: _____

Consent for Treatment of Minor Child

I give permission to Donay Chiropractic Center to administer chiropractic care as deemed necessary to my child_____.

(Name of Child)

Patient Parent or Legal Guardian Signature: _____

Witnessed: _____Date _____