

Please fill out the following form in as much detail as possible.

Name: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Birthday: _____ Phone Number: _____

Marital Status: ___S ___M ___D ___W Spouse's name: _____

of Children: _____ Names: _____

What is your chief complaint?

How do you believe your problem began?

Have you ever had this condition or something similar before? When? _____

What makes it better? _____

What makes it worse? _____

Have you been under the care of another health care provider for this condition? When? _____

Do you have any other health concerns? _____

Have you ever been in any accidents (ie. Auto, falls from stairs or ladders), even as a child? _____

What surgeries have you had? _____ Year _____

_____ Year _____

_____ Year _____

Are you pregnant? _____ If yes, what is your due date? _____

What medication are you taking? (Including aspirin, etc) _____

What vitamins and supplements do you take? _____

Habits: (please check):

Cigarettes _____ *Quantity:* _____ Alcohol _____ *Quantity:* _____

Coffee _____ *Quantity:* _____ Pop _____ *Quantity:* _____

Tea _____ *Quantity:* _____ Water _____ *Quantity:* _____

Do you exercise? How often? What activities? _____

Current: Height: _____ Weight: _____

Have you lost or gained weight in the past year? How much? _____

How do you characterize your stress levels? (Please check)

_____ High _____ Medium _____ Low

Do you have a family history of: (Please mark M for mother, F for father, S for sibling)

_____ High Blood Pressure _____ Thyroid Disease _____ Stroke _____ Cancer

_____ Heart Disease _____ Headaches _____ Osteoporosis _____ Back Pain

_____ Depression or Anxiety _____ Stroke _____ Arthritis _____ Diabetes

Is there anything else in your health history that we should know about? _____

Have you **recently had** or **do you now have** any of the following symptoms which are or have been significant distress to you?

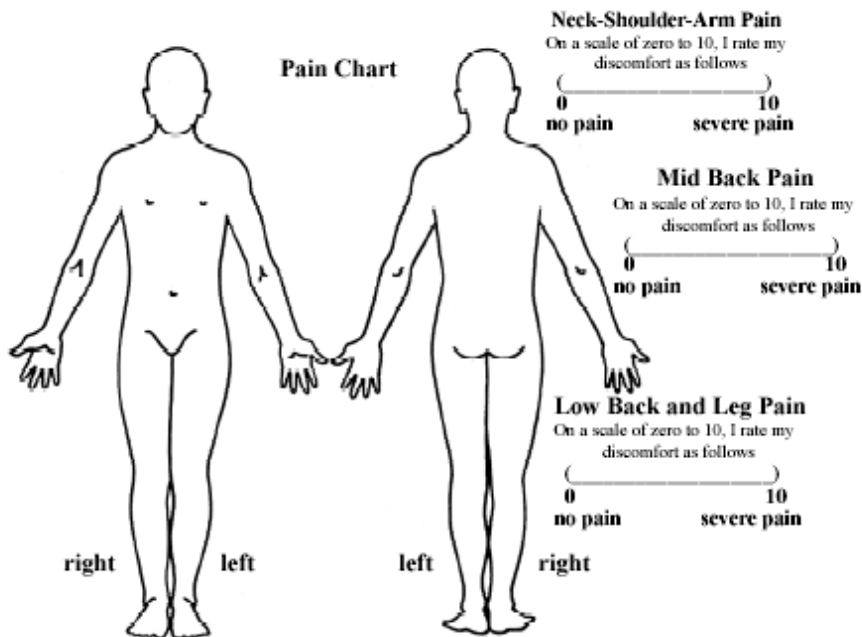
	Now	Past		Now	Past
Headaches	_____	_____	Loss of Balance	_____	_____
Neck Pain	_____	_____	Sleeping Problems	_____	_____
Stiff Neck	_____	_____	Loss of Smell	_____	_____
Fainting	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Diarrhea	_____	_____
Nervousness	_____	_____	Feet Cold	_____	_____
Tension	_____	_____	Hands Cold	_____	_____
Irritability	_____	_____	Arthritis	_____	_____
Chest Pains	_____	_____	Muscle Spasms	_____	_____
Dizziness	_____	_____	Frequent Colds	_____	_____
Upset Stomach	_____	_____	Shoulder/Neck/Arm Pain	_____	_____
Constipation	_____	_____	Pins & Needles in Arm	_____	_____
Cold Sweats	_____	_____	Pins & Needles in Legs	_____	_____
Fever	_____	_____	Numbness in Fingers	_____	_____
Sinus Problems	_____	_____	Numbness in Toes	_____	_____
Diabetes	_____	_____	High Blood Pressure	_____	_____
Hemorrhoids	_____	_____	Difficulty Urinating	_____	_____
Allergies	_____	_____	Leg Cramps	_____	_____
Colitis	_____	_____	Weakness in Arms	_____	_____
Gall Bladder	_____	_____	Weakness in legs	_____	_____
Indigestion	_____	_____	Shortness of Breath	_____	_____
Fatigue	_____	_____	Menstrual Difficulties	_____	_____
Depression	_____	_____	Vomiting	_____	_____
Shoulder Pain	_____	_____	Lights Bother Eyes	_____	_____
Swelling Joints	_____	_____	Loss of Memory	_____	_____
Ears Ring	_____	_____	Knee Pain	_____	_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	OOOOO	XXXXX	*****	/////
-----	OOOOO	XXXXX	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



**DOLAN FAMILY CHIROPRACTIC LLC
PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS**

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. Dolan Family Chiropractic Privacy notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for Dolan Family Chiropractic and to provide treatment to me, and also necessary for the Dolan Family Chiropractic to obtain payment for that treatment and to carry out it’s health care operations. Dolan Family Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. The Dolan Family Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy notice carefully prior to my signing this Consent.
2. Dolan Family Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by Dolan Family Chiropractic: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. Dolan Family Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Dolan Family Chiropractic to treat me and obtain payment for that treatment, and as necessary for Dolan Family Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that Dolan Family Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Dolan Family Chiropractic is not required to agree to any restrictions that I have requested. If Dolan Family Chiropractic agrees to a requested restriction, then the restriction is binding on Dolan Family Chiropractic.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Dolan Family Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, Dolan Family Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then Dolan Family Chiropractic will not treat me.

I have read and understand that foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a
minor):

Relationship

Date Signed ____/____/____

Witness: _____