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?

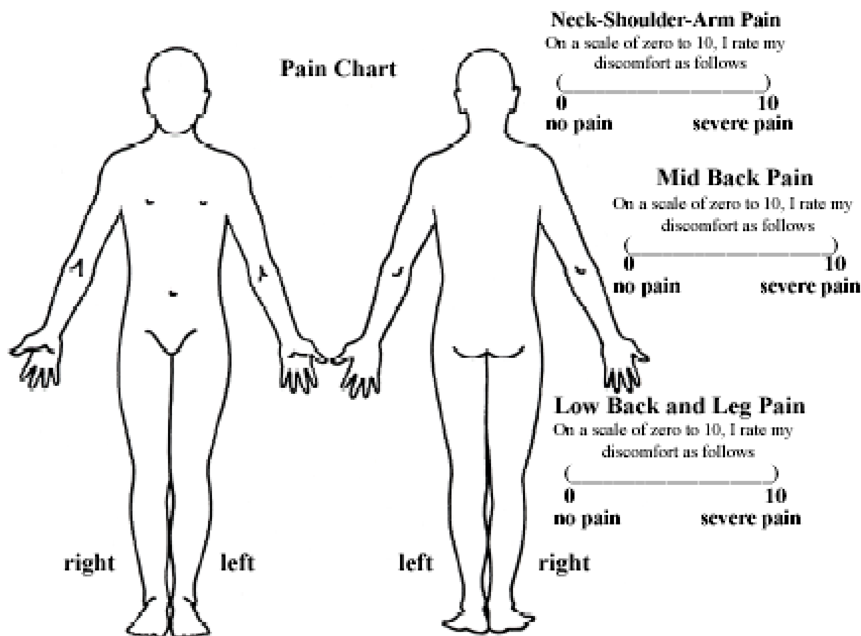
	Now	Past		Now	Past
Headaches	____	____	Loss of Balance	____	____
Neck Pain	____	____	Sleeping Problems	____	____
Stiff Neck	____	____	Loss of Smell	____	____
Fainting	____	____	Loss of Taste	____	____
Back Pain	____	____	Diarrhea	____	____
Nervousness	____	____	Feet Cold	____	____
Tension	____	____	Hands 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 Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed _____/____/____ Witness:_________________________