Dooley Chiropractic

Optimize Your Health

NEW PATIENT INFORMATION FORMS:

Completing this form with as much detail as possible will allows us the opportunity to learn more about you, your history, any trauma (such as motor vehicle accidents, etc…), as well as a quick look at your current state of health and wellbeing. The more detailed you are with your responses, the better prepared we become, thus optimizing your health potential.

Thanking you in advance!

Today's Date: _____ Patient Account # _____

Legal FIRST Name: _____ MI: _____ LAST Name: _____

Street: _____Apt: _____

City: _____ State: _____ Zip: _____

DOB: _____/_____/_____ Current Age: _____

Marital Status (Circle One): S M W D DP Significant Other: _____

Home Phone: _____ Cell Phone: _____ Cell Provider: _____

Please circle your contact preference: Home Work Cell Email US Postal Mail

Email (H): _____ Email (W): _____

Emergency Contact:_____ Phone Number: _____

Your Occupation: _____ Employer: _____

Prior Chiropractic Care: Yes ☐ No ☐ Name(s): _____

Results: _____

General Practitioner's Name: _____

Whom may we thank for referring you to our office? _____

Have you had same or similar problem(s) to the CURRENT chief complaint before? Yes □ No □

If so, how long? Please explain: _____

Has this problem been "Staying the SAME" or "Getting BETTER" or "Getting WORSE"

Father/Mother/Brother/Sister/Children, with similar problems? Yes □ No □ _____

Is this the result of a Work related Injury? Yes □ No □ If so, have you reported this at work? Yes □ No □

Is this the result of an Automobile (MVA) or Personal Injury? Yes □ No □

If so, have you reported this to anyone? Yes □ No □

List any other doctors who have treated this problem: Yes □ No □ _____

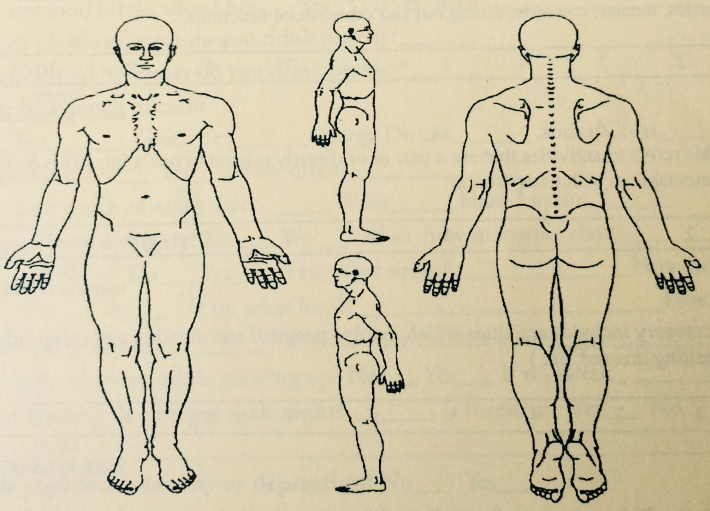
VISUAL ANALOG PAIN SEVERITY SCALE

Instructions: Please place a mark on the line that corresponds to your current pain levels for each complaint.

Absence ——— Extreme

Indicate below, the location and type of pain that is current or ongoing.

Numbness = = = = Pins and Needles o o o o Burning x x x x Stabbing / / / / / Aching a a a a



FACT FINDING DATA:

Please mark the above illustration listing your current state of "PAIN" and/or "DISCOMFORT" and circle areas affected. (If there is nothing significant or noteworthy, there are no circles, lines, or dashes required)

Health reasons for contacting our office – List your Chief Complaints in order of severity with #1 being the WORST!

1._____ **2.**_____

3._____ **4.**_____

Are you taking ANY Medication(s)?: Yes □ No □ If YES, please list them on page #3.
Is there any chance you are pregnant? Yes □ No □
Have you ever been diagnosed with cancer? Yes □ No □
Do you have a pacemaker? Yes □ No □

What is your level of commitment to yourself, your life, and your overall wellbeing? High: ☐ Medium: ☐ Low: ☐

What daily rituals for spinal health do you presently practice (aka: Do you exercise, daily)? Yes □ No □

Please describe: _____

Past health history:

Have you been hospitalized in the last 5 years? Yes □ No □
Have you been diagnosed with Diabetes? Yes □ No □
If YES, please list info below under Additional Notes/Comments. Type I____ or Type II_____
Have you been treated for hypertension? Yes □ No □ If YES, please list info below under Additional Notes/Comments.

Wellness information:

Please answer the following questions on a scale of 1-10 with 10 being the best/most.

General State of Well-being ____/10; General Outlook and Attitude: _____/10; Average Level of Stress _____/10.
In the past 30 days, how many days have you felt healthy and full of energy? _____
In the past 30 days, how many days was your physical health not good? _____

Do you smoke? Never: □ Former Smoker: □ Current/Every day Smoker: □ Current/Some Day Smoker: □
Do you drink alcohol? Never: □ Yes □ How often? _____ How much per Day: _____
What is your daily intake of filtered water per day? _____ ozs. Current weight? _____
How many hours of restful sleep do you get each night? _____ How old is your mattress? _____
Diet & Nutrition: How many meals do you eat every day? _____ Do you skip meals? _____
Any recent changes to your diet? Yes □ No □ List those changes: _____
Do you have allergies? Food: □ Environmental: □ Medication: □
List Type of Allergy and Reaction:

_____

Additional Notes/Comments:_____

_____

_____

When a patient seeks chiropractic healthcare and Dooley Chiropractic accepts the patient, it is essential for both parties to be working towards the same objective, along with the same goals. I state this because it is my intention to be clear from the start, hopefully this will prevent any confusion and/or disappointment.

Chiropractic only has one goal, and it is the correction of specific adjustments to the spine and extremities.

The term "adjustment" is best described as: The specific application of forces to facilitate the body's correction of a vertebral subluxation.

The term "Vertebral Subluxation" is best described as: The misalignment of one or more of the 24 vertebrae in the spinal column which cause alteration of nerve function and interference to the transmission of afferent (incoming) impulses, and therefore, bad efferent (outgoing) impulses resulting in the reduction of the body's innate ability to express your maximum health potential.

We do not diagnose and/or to treat any disease or condition other than correcting vertebral subluxations and assistance with your nutrition habits.

However, if during the chiropractic spinal examination, x-ray findings, neurological or orthopedic tests and physical exams where we encounter non-chiropractic or unusual findings, we will advise you.

If you desire further advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that specific field. Regardless of what the disease is called, we do not offer to treat it; nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations and nutrition assistance, as mentioned.

The term "Health" is best described as: The state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

I understand that, as part of my healthcare, Dooley Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment of care, and any plans for future care or treatment. I understand that this information serves as a basis for planning my healthcare and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and treatment information to my bill, a means by which a third-party payer can verify that services billed were provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. Sharing of these methods will be done in compliance within the guidelines according to HIPPA requirements.

I further understand that Dooley Chiropractic reserve the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dooley Chiropractic change their notice, they will send a copy of any revised notice to the address provided (whether U. S. Mail or, if I agree, email).

Patient Responsibility Policy

I understand that it is my responsibility, as a patient of Dooley Chiropractic to reach out to the Clinic to cancel, reschedule, and/or change a scheduled appointment. This agreement acknowledges my role in achieving this courtesy.

I understand that I play a very active role in my overall health & well-being, and I know that I need to eat well, perform the required rehab exercises, and stay properly hydrated, allowing my body to repair any damaged tissue which is causing my body's dysfunction.

I understand that if I miss my appointment, cancel, or change my appointment with less than a twenty-four (24) hour notice, I will be charged $55.00.

This policy is in place out of respect for our doctors, staff and our other patients attempting to secure time with the Doctor. Cancellations with less than a 24-hour notice are difficult to fill.

Thank you for your understanding and cooperation on this matter.

I, _____ have read this policy and I understand my responsibility as a patient of this clinic to honor my commitment to my health and those around me.

Patient's Signature: _____ Date:_____/_____/_____

Patient's Parent's/Guardian's Signature: _____ Date:_____/_____/_____

Informed Consent to Care

You are the decision maker for your health care and the health and welfare of your family. Part of our role is to provide you with current information that is science based and peer-reviewed to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose to receive and or not to receive any care.

We will conduct diagnostic and examination procedures, where appropriate and indicated. Any examinations or tests conducted will be carefully performed and may be uncomfortable. We promise to always have your health and best interest in every task.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures and/or recommendations, as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, mostly vertebrae, although other boney structures are included. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (blood clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3 to 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent.

I appreciate that it is not possible to consider every possible complication to care.

I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance.

I intend this consent to cover the entire course of care from the providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____