DOLAN CHIROPRACTIC

New Patient Form

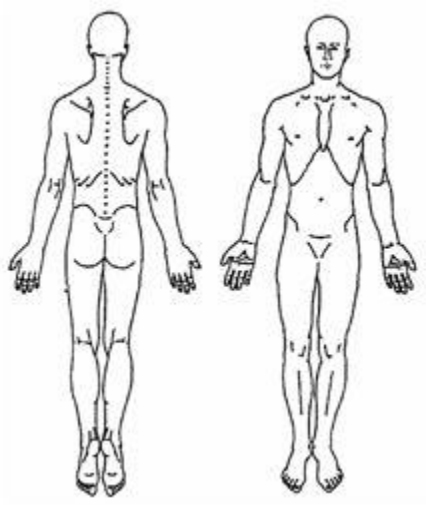
Full Name: _____
Called Name: _____ Address: _____
City:_____ State:_____ Zip Code:_____
Phone: _____ Work: _____Cell:_____
Email Address: _____ Sex: __ M __ F
Marital Status: ___ Married ___ Single ___ Widowed ___ Divorced
Birth Date:_____ Work Status: ___ Employed ___ Retired ___ Student
Referred By: _____

Patient Condition:
Reason for Visit: _____
Date condition began: _____
Rate the severity of your pain on a scale of 1(least pain) to 10(severe pain) _____

Areas of Concern

Please mark all areas of pain – be specific
Check any body signals you may have noticed

__ Headache
__ Neck Pain
__ Cold Sweats
__ Sleeping Problems
__ Tension
__ Chest Pain
__ Numbness in fingers
__ Numbness in toes
__ Depression
__ Ears Ring
__ Loss of balance
__ Diarrhea
__ Back Pain
__ Face Flushed
__ Stomach Upset
__ Loss of Taste



__ Irritability
__ Stiff neck
__ Shortness of breath
__ Nervousness
__ Dizziness
__ Pins & needles-arms
__ Pins & needles-legs
__ Fatigue
__ Loss of memory
__ Fainting
__ Fever
__ Constipation
__ Feet Cold
__ Hands Cold
__ Loss of smell
Other: _____

Have you seen any other doctors for this condition? ___ Yes ___ No

Doctor/Date Seen/Treatment

Health History – Check Conditions that apply to you:

__ Cancer __ Concussion __ High Blood Pressure __ Polio __ Tuberculosis __ None
__ Stroke __ Anemia __ Muscular Dystrophy __ Epilepsy __ Heart Problems
__ Arthritis __ Asthma __ Digestive Disorders __ HIV/AIDS __ Hepatitis

Please list any major illness or surgeries: _____

_____

_____

List all medications including supplements: _____

_____

_____

_____

Habits
__ Smoking
__ Alcohol
__ Coffee

Stress Level
___ None
___ Light
___ Moderate
___ Severe

Work Activity
__ Sitting
__ Standing
__ Labor
__ Computer

Exercise
__ None
__ Daily
__ Moderate
__ Heavy

Review of Systems

Are you <u>currently</u> experiencing any of these symptoms? (Please select all that apply)

Constitutional: (General)
___Fever
___Fatigue
___Other:_____
___None in this Category

Musculoskeletal:
___Joint Pain/Stiffness/Swelling
___Muscle Pain/Stiffness/Spasms
___Broken Bones _____
___Other:_____
___None in this Category

Neurological:
___Dizziness or lightheaded
___Convulsions or Seizures
___Tremors
___Other:_____
___None in this Category

Psychiatric: (Mind/Stress)
___Nervousness/Anxiety

___Depression
___Sleep Problems
___Memory Loss or Confusion
___Other:_____
___None in this category

Genitourinary:
___Frequent or Painful Urination
___Blood in Urine
___Incontinence or Bed Wetting
___Painful or Irregular Periods
___Other:_____
___None in this Category

Gastrointestinal:
___Loss of Appetite
___Blood in Stool or Black Stool
___Nausea or Vomiting
___Abdominal Pain
___Frequent Diarrhea
___Constipation
___Other:_____
___None in this Category

Cardiovascular & Heart:
___Chest Pains/Tightness
___Rapid or Heartbeat Changes
___Swelling of Hands, Ankles, or Feet
___Other:_____
___ None in this Category

Respiratory:
___Difficulty breathing
___Cough
___Other:_____
___None in this Category

Eyes & Vision:
___Eye Pain
___Blurred or Doubled Vision
___Sensitivity to light
___Other:_____
___None in this Category

Head, Ears, Nose & Mouth/Throat
___Frequent or Recurrent Headaches
___Ear-Ache/Ringing/Drainage
___Hearing Loss
___Sensitivity to Loud Noises
___Sinus Problems
___Sore Throat
___Other:_____
___None in this Category

Endocrine:
___Infertility
___Recent Weight Change
___Eating Disorder
___Other:_____
___None in this Category

Hematologic & Lymphatic:
___Excessive Thirst or Urination
___Cold Extremities
___Swollen Glands
___Other:_____
___None in this Category

Integumentary: (Skin, Nails, & Breasts)
___Rash or itching
___Change in Skin, Hair, or Nails
___Non-Healing Sores or Lesions
___Change of Appearance of a Mole
___Breast Pain, Lump, or Discharge
___Other:_____
___None in this Category

Allergic/Immunologic:
___Food Allergies
___Environmental Allergies
___Other:_____
___None in this Category

Review of Systems Comments

Consent to Treat and HIPAA Privacy Information

The nature of the chiropractic adjustment
The primary treatment used as a Doctor of Chiropractic is spinal manipulative therapy. I will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" of "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures. **Please initial each treatment that you are consenting to.**

__ Spinal manipulative therapy
__ Range of motion testing
__ Muscle strength testing
__ Radiographic studies
__ Palpation
__ Orthopedic testing
__ Postural testing
__ Spinal decompression
__ Vital signs
__ Basic neurological testing
__ NES Scan

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to, or contributing to, serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care: however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during the examination and X-Ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in five million cervical adjustments. Other complications that may arise are also generally described as rare.

The availability and nature of other treatment options:
Other treatment options for your condition may include:

- Self administered, over-the-counter analgesics and rest
- Prescription drugs such as anti-inflammatory, muscle relaxers, and pain-killers
- Medical Care of Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read | | or have had read to me | | the above explanation of the chiropractic adjustment and related treatment. I have discussed with Dr. Dolan and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I am also aware that Dolan Chiropractic has made the HIPAA Privacy Practices readily available for my viewing.

_____

Patient/Guardian Signature Date

SLEEP WELLNESS PATIENT INTAKE QUESTIONS

PATIENT NAME:_____**DATE:**_____

1. On a scale of 1 – 10, with 10 being the WORST, about how well do you sleep? ____

2. About how many hours per night do you sleep on average? _____hours

3. Do you toss and turn frequently? _____yes _____no _____not sure

4. Do you wake up with pain in the morning? _____yes _____no

5. If yes, where is that pain located? _____R hip _____L hip _____R shoulder _____L shoulder _____neck _____back _____other: _____

6. How severe would you rate that pain in each area on a scale of 1 – 10, with 10 being Greatest Amount of Pain? _____R hip _____L hip _____R shoulder _____L shoulder _____neck _____back _____other:_____

7. What type of mattress do you sleep on? _____pillow top _____firm _____innerspring _____latex core _____memory foam core _____don't know

8. About how old is your mattress? _____0-2 years _____3-5 years _____5-8 years

_____9-12 years _____13+ years

9. Do you take anything to help you sleep? _____alcohol _____sleeping medication _____pain medication _____natural herbs (melatonin, chamomile, etc.) _____other: _____

10. Do you wake up refreshed in the morning? _____yes _____no

11. Do you understand the role sleep plays in healing and wellness? _____yes _____no

12. What type of pillow do you currently use? ____pillow ____foam ____down ____latex

_____air _____water _____don't know

13. How happy are you with your pillow? _____very _____just okay _____not very _____not at all

14. Do you or your significant other snore _____suffer from allergies _____have morning headaches_____

15. Do you have trouble falling asleep _____ yes _____no

16. Do you have trouble staying asleep _____yes _____no