

Dr. Douglas Drobbin, D.C.
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drobbinchiropractic@gmail.com

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____ Age: _____

Home phone: _____ Cell: _____ Work: _____

Referred by: _____

Married: _____ Single: _____ Divorced: _____ Number of Children: _____

Do other family members receive chiropractic care? Yes _____ No _____ Who? _____

Occupation: _____ Years at present job? _____

Business Address: _____

Email: _____

Do you have health insurance? Yes _____ No _____ Name of Insurance company _____

Previous chiropractic care? Yes _____ No _____ When? _____ Dr's name: _____

Previous spinal X-rays? Yes _____ No _____ When? _____ Reason _____

Did an injury occur: On the Job/ Auto Accident/ Other _____

Briefly describe present complaint: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company except, from Medicaid and workman's compensation, and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Patients signature: _____ Date: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Drobbin Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill or to conduct health care operations of Drobbin Chiropractic. I understand that diagnosis or treatment of me by Drobbin Chiropractic may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Drobbin Chiropractic is not required to agree to the restriction that I may request. However, if Drobbin Chiropractic agrees to a restriction that I request, the restriction is binding on Drobbin Chiropractic and Dr. Douglas Drobbin.

I have the right to revoke this consent, in writing, at any time, except to the extent that Drobbin Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Drobbin Chiropractic's Notice of Privacy Practices prior to signing this document. The Drobbin Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Drobbin Chiropractic. This Notice of Privacy Practices also describes my rights and the Drobbin Chiropractic's duties with respect to my protected health information.

Drobbin Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by Drobbin Chiropractic's by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Drobbin Chiropractic

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustment are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle

Signature

Date

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Please check any of the following symptoms of ill health, which you may now have or have had previously. In order to provide necessary chiropractic care we need to know all the facts related to your health. This is a Confidential Health Report.

- | | | |
|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Stiff | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Pins + Needles in Arms | <input type="checkbox"/> Tension | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Pins + Needles in Legs | <input type="checkbox"/> Irritability | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Pain in the Arms | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Pain in the Legs | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Pain between Shoulders | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Depression | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Eyes Sensitive to Light | <input type="checkbox"/> Chronic Cough |
| L/R Shoulder | L/R Elbow | L/R Wrist |
| L/R Hip | L/R Knee | L/R Ankle |

Have you ever?

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Been Knocked Unconscious? |
| <input type="checkbox"/> | <input type="checkbox"/> | Used Crutches or other Support? |
| <input type="checkbox"/> | <input type="checkbox"/> | Been Treated for Spine Problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Been Treated for any Nerve Disorder? |
| <input type="checkbox"/> | <input type="checkbox"/> | Had a Fractured/Broken Bone? |
| <input type="checkbox"/> | <input type="checkbox"/> | Had Surgery? |
| <input type="checkbox"/> | <input type="checkbox"/> | Been Hospitalized for Other than Surgery? |

Date of Last: (approximate)

- | | |
|-------|----------------------|
| _____ | Physical Examination |
| _____ | Blood Test |
| _____ | Urine Test |
| _____ | Chest X-ray |
| _____ | Spine X-ray |
| _____ | Dental X-ray |
| _____ | Other |

Habits:

Have you in the past or do you currently use:

Alcohol If yes, how often?

Coffee How many cups per day? _____

Tobacco How many packs per day? _____

Your Current Problem – What are your current symptoms?

1. _____
2. _____
3. _____
4. _____

What level of intensity would you rate your pain? (10 = severe) **1 2 3 4 5 6 7 8 9 10**

What is the frequency of your symptoms? **Occasional / Episodic / Intermittent / Frequent / Constant**

Do your symptoms affect your personal life? (hobbies, sports, etc.)

Do your symptoms affect your job / occupation? (missed days, inability to stand, sit, lift, drive)

How long have you suffered from these symptoms?

Have you suffered from these symptoms before? Yes No

What makes your symptoms worse?

What makes your symptoms better?

What home remedies have you tried?

Have you been to any other type of doctor for this problem?

After completing this questionnaire your signature will verify that all information you have given is accurate to the best of your knowledge.

Signed: _____ Date: _____

Name _____ Date _____

Answer yes or no to the following question. If yes, explain where necessary.

Do you sleep 6-8 hours of deep uninterrupted sleep every night?

Do you have at least 1 bowel movement every day?

Do you have: allergies/sinus/congestion symptoms, or asthma?

Do you have: frequent/urgent or nighttime urination?

Do you feel: bloated, gassy, stomach distress, sour burps, hiatal hernia, or heartburn?

Do you have: arthritis or achy/painful joints?

Do you have: varicose veins or bruise easily?

Are you: tired all the time/wake up tired/sleepy at 3 p.m.?

Do your ankles swell or do you have leg cramps at night?

Do you have low resistance or are you sick often?

Describe your dental health.