Dade Donovan DC 700 S. Claremont Street #111 San Mateo CA 94402 650-348-4233 Fax 650-240-0795

PATIENT INTRODUCTION FORM

Name: **Date:**	Work Telephone:
Address:	Email Address:
City/State/Zip:	Employer's Name:
Date of Birth: Age:	Job Title/Description:
Height: Weight:	Marital Status (**Circle**): Single, Married, Divorced, Widowed
Primary Contact Telephone: Prefer: email, text or phone reminders(circle one)	How did you hear about our office?

Name and Telephone of your nearest adult relative (for emergencies):____________________

Your Primary Care Physician's Name and Address____________________

May we provide the results of your care to this Physician? Yes ☐ No ☐

Our office will provide insurance billing services for you as a courtesy, if you desire. It should be understood that many insurance policies cover Chiropractic care. We however, cannot make any specific representations that yours does. Please note that insurance does often change throughout the policy year, often without notice. Ultimately you are responsible for charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to have your insurance company pay our office directly or to pay for any outstanding bills incurred in this office should they fail to.

TO KEEP OVERHEAD AND FEES REASONABLE, WE EXPECT AND APPRECIATE PAYMENT AT THE TIME OF SERVICE.

We do request 24 hours notice should you need to cancel an appointment to allow us to offer that appointment to others. We reserve the right to charge for late cancellations or no-shows.

Signature of responsible party (Patient or Parent): ____________________ Date: ____________

Tell us why and where it hurts.

☐ Work Related Injury ☐ Motor vehicle Injury ☐ Sports or Recreational Injury ☐ Non-Injury Symptoms ☐ Check-up Only

☐ Other (Describe):____________________

CIRCLE YOUR LEVEL OF PAIN TODAY (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN EVER)

What does this scale mean? A zero score indicates no symptoms. A 1-3 pain level is a minimum level and indicates that your pain is an annoyance only. A 4 pain level is a moderate and pain during activity begins to interfere with you doing that activity. A 5-7 pain is moderate in severity and has to restrict or limit your activity tolerance to a significant degree. An 8-10 level is severe and indicates that your pain intensity is to a point where you are unable to perform regular activity.

When and how did your pain begin?____________________

Where is the pain located? ____________________

What makes the pain worse? ____________________

What makes the pain better? ____________________

How is the condition interfering with your life?____________________

Have you injured or had pain in this area before? ____________________

Do you have other symptoms related to this pain? (dizziness, stomach upset etc.)____________________

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PAST AND PRESENT GENERAL HEALTH HISTORY

Check those conditions that apply to you:

GENERAL HEALTH QUESTIONS	Yes
Smoke cigarettes or use tobacco products/Asthma/Other lung problems	☐
Diabetic or Pre-Diabetic Type 1 or Type 2	☐
Do you have a pacemaker, neck or chest shunt, or problems lying face down?	☐
History of heart attack or chest pain not relieved by rest	☐
I have currently, or a history of Dizziness or fainting spell history	☐
Current or history of Epilepsy-Seizures-Convulsions	☐
History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	☐
Cancer history or treatment of any type	☐
Stroke history (Suspected strokes or Other unexplained loss of consciousness)	☐
Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	☐
Told that you have spina bifida, abdominal aneurysm, or vascular conditions	☐
Have you ever been hospitalized? Why:	☐
Thyroid disorders (type)	☐
I have been in a Coma, suffered a concussion or head injury, or other loss of consciousness	☐
Told you have osteopenia or osteoporosis, date of last test if any ______	☐
Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	☐
How many hours do you sleep per night? Do you feel rested on waking?	☐
Other conditions not previously mentioned?	☐

HISTORY OF INJURY OR PAIN

(☐ **I have no history of previous injury or pain**) If you have had any **prior** injuries or pain, please check below:

☐ Work Injury ☐ Fall ☐ Sports Injury ☐ Lifting Injury
☐ Car vs Bike/Pedestrian Injury ☐ Car accident(s) ☐ Middle Back Pain ☐ Low Back/Leg Pain
☐ Headaches/Migraines ☐ Neck Pain or Arm Pain ☐ Other

Additional information ______

HAVE YOU EVER BROKEN BONES?

Region/Year/Outcome	Region/Year/Outcome
(☐ **I have never had any broken bones).** If you have broken any bones, indicate where and when:	
☐ Spinal Column Fracture	☐ Skull Fracture
☐ Collar bone Fracture	☐ Rib Fracture
☐ Arm or hand Fracture	☐ Leg or Foot Fracture
☐ Pelvis or Hip Fracture	☐ Other Fracture ( )

OR SURGERY ?

(☐ **I have never had any surgical procedure).** If you have had any previous surgery, indicate type and when:

☐ Disc surgery in neck or back	☐ Shoulder/Arm/Leg
☐ Heart/Lung	☐ Abdominal
☐ Cancer (any type)	☐ Other ( )
☐ Head/Brain	☐ Other ( )

RECENT OR CURRENT SYMPTOMS OTHER THAN CHIEF COMPLAINT

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
☐ Headaches		☐ Upper Back Pain, Soreness, Stiffness	
☐ Neck Pain, Soreness, Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, Tingling	
☐ Arm/Hand Pain, Numbness, Tingling		☐ Other	

Form 1300

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PAST AND PRESENT GENERAL HEALTH HISTORY (Page 2)

Have you ever been to a Chiropractor before for this or any other condition?

☐ No, ☐ Yes, Chiropractors Name : ______________________ Year: __________

Problem seen for: ______________________ Results: ______________________

Why did you discontinue care? ______________________

PLEASE LIST ANY MEDICATIONS/SUPPLEMENTS YOUARE CURRENTLY TAKING?

☐ **I am not taking any medications currently.** Check the following that you are taking.

☐ Muscle Relaxants	☐ Aspirin/ Anacin/ Bufferin	☐ Cholesterol Medication (Lipitor/Zocor/etc.)
☐ Allergy Medication	☐ Tylenol/ Advil/Motrin	☐ Wellbutrin/ Prozac/ Elavil/ Other (______)
☐ Narcotics for Pain (Vicodin etc.)	☐ Migraine Medication	☐ Stroke prevention meds (Coumadin)
☐ Heart medications	☐ Birth control medications	☐ Other Medication/Supplements (______________)

WHEN IS YOUR PAIN USUALLY BETTER?

☐ Morning	☐ Afternoon	☐ Evening
☐ During sleep hours	☐ When lying down flat/Rest	☐ Standing
☐ Walking	☐ Sitting	☐ Exercise/Stretching/Moving
☐ When Stress (mental) is less	☐ Good posture	☐ Other

HAS YOUR PAIN BEEN ASSOCIATED WITH?

☐ When tired	☐ Balance problems/Dizziness	☐ Night pain or night time sweats
☐ Weight loss	☐ Abdominal pain/Stomach pain	☐ Coughing or sneezing
☐ Fever	☐ Using the restroom	☐ Exercise

WHAT IS YOUR DAILY PHYSICAL ACTIVITY LEVEL?

☐ Mostly sitting	☐ Light manual labor	☐ Moderate to heavy manual labor
☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I do regular sports activities	☐ I am not willing to do exercises

Is there anything else that you feel may be important that has not been mentioned?

____

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PAIN DRAWING

Name ______________________________ Date __________

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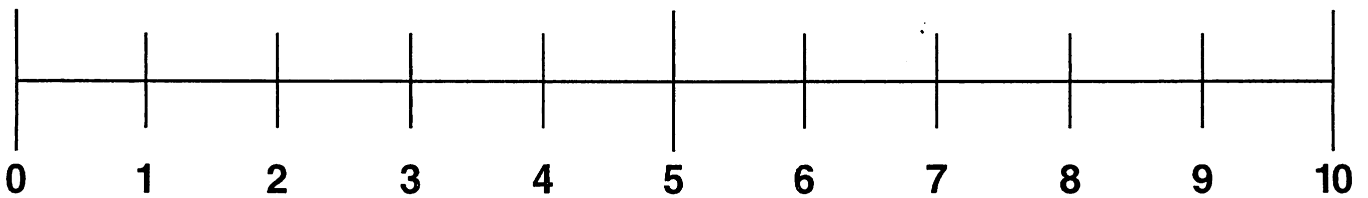
R L



Mark as follows:

A - Ache B - Burning N - Numbness P - Pins & Needles

S - Stabbing O - Other - Describe ______________________________

Chiropractic Offices of Dade Donovan D.C.
700 South Claremont Street #111 San Mateo CA 94402

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The office of Dade Donovan D.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. For example:

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with our practice."*
>
> *"It is our policy to provide a substitute health care provider, authorized by our practice to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. For example:

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to our practice for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Office Operations.

We may contact you, as described below:

"It is our policy to place a reminder call on the evening prior to your appointment. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording.

This notice is effective as of the date of signature.

By way of my signature, I provide the office of Dade Donovan D.C. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patients Name ________________________ Patient's Signature__________________ Date__________

Dade W. Donovan DC, 700 S. Claremont #111, San Mateo, CA 94402 650-348-4233

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, and physical therapy techniques (including ultrasound, muscle stim and Myofascial Release: ART, Graston techniques) on me (or the patient named below, for whom I am legally responsible) by Dr. Donovan and/or other licensed Doctor of Chiropractic who now or in the future render treatment to me while employed by Dr. Donovan.

I understand that, as with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. These complications may include but are not limited to fractures, disc injuries, dislocations, and muscle strains and sprains. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure(s) which the doctor feels, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with Dr. Donovan and /or with other office or clinic personnel the nature, purpose and risk of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction. I understand that results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ, DISCUSSED WITH THE DOCTOR, AND UNDERSTAND THE ABOVE

______________________________	______________________________
Print Patients Name	Print Name of Patient's Representative
______________________________	______________________________
Signature of Patient or Representative	Relationship of Patient Representative
______________________________	______________________________
Date Signed	Doctors Signature
______________________________	
Translated or read by	

Dade W. Donovan, D.C.
700 S. Claremont Street #111 San Mateo CA 94402
Phone 650-348-4233, Fax 650-240-0795

"Out-of-Network" Time of Service Financial Agreement

It is our policy that payment is made in full at the time of services are rendered, unless otherwise agreed.

Initial Examination Fee $135
Chiropractic Adjustment $70
Active Release Technique (ART) $70
Active Release Technique (ART), if performed with Chiropractic Adjustment $30
Subsequent Re-Examination $50 to $95 (as necessary, to evaluate new conditions and/or significant re-injuries)
Modalities (Ultrasound, Muscle Stimulation, Traction) $25

Important Office Policies:

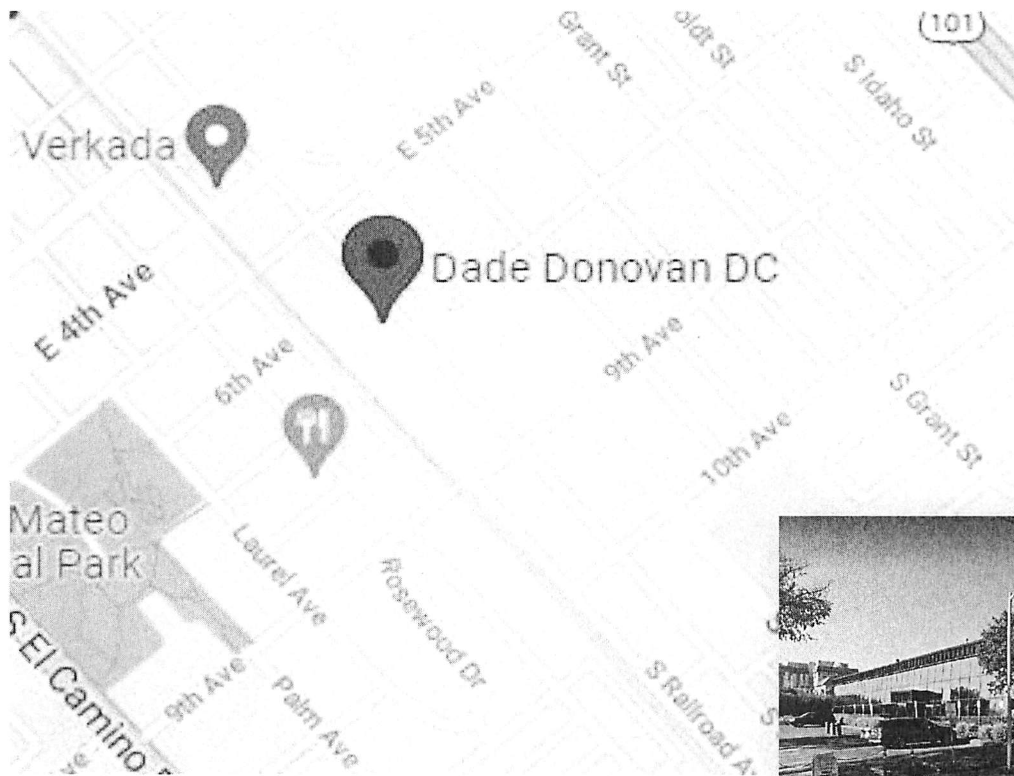
OUT OF NETWORK POLICY
Patients with out of network insurance. We are happy to submit billing for you to your insurance carrier. However, some insurers have in recent years began requiring additional paperwork. This additional paperwork we are not able to perform.

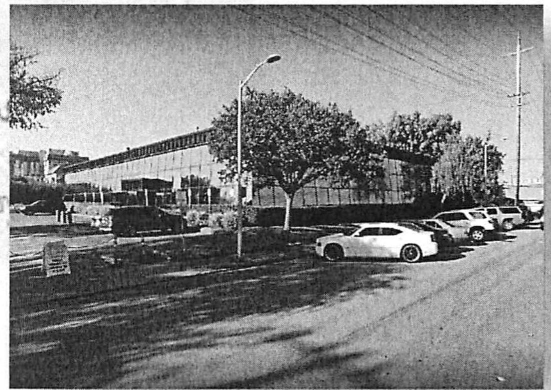
______________ I authorize the release of any medical or other information necessary to process this claim.

LATE CANCELLATION/NO-SHOW POLICY
We have a **24-hour cancellation policy**. If you cancel with less than 24 hours' notice, we reserve the right to charge for the missed appointment. Messages may be left on our answering machine at any time to cancel an appointment. Additionally, if you are late for your appointment, this will cut into your treatment time and the session will still be billed accordingly. This charge will not be reimbursed by insurance. Thank you in advance for keeping your scheduled appointment and for helping us in providing the highest level of care for you and your family members. As a courtesy, an email, text, or phone reminder will be sent the day prior to your visit.

By my signature below, I understand and agree with the above office policy.

______________________ ______________________
Patient Signature Date





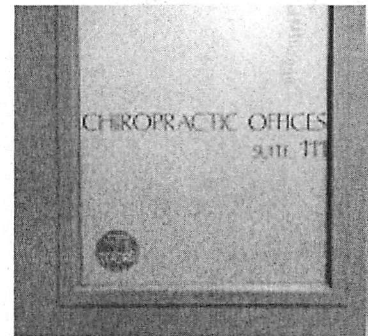
Dade Donovan, DC

700 S. Claremont, Suite 111

San Mateo, CA 94402

(Take a left when you enter building,

Suite 111 is at the end of the hallway)



T. 650-348-4233

E. info@drdade.com

W. www.drdade.com

We schedule your first appointment for one hour. Please contact our office at least 24 hours prior to your appointment if you need to change your reserved time.