

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

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:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury
<input type="checkbox"/> Car vs Bike/Pedestrian Injury	<input type="checkbox"/> Car accident(s)	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back/Leg Pain
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain or Arm Pain	<input type="checkbox"/> Other	
Additional information _____			

HAVE YOU EVER BROKEN BONES?

Region/Year/Outcome	Region/Year/Outcome
<input type="checkbox"/> I have never had any broken bones). If you have broken any bones, indicate where and when:	
<input type="checkbox"/> Spinal Column Fracture	<input type="checkbox"/> Skull Fracture
<input type="checkbox"/> Collar bone Fracture	<input type="checkbox"/> Rib Fracture
<input type="checkbox"/> Arm or hand Fracture	<input type="checkbox"/> Leg or Foot Fracture
<input type="checkbox"/> Pelvis or Hip Fracture	<input type="checkbox"/> Other Fracture (_____)

OR SURGERY ?

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

<input type="checkbox"/> Disc surgery in neck or back	<input type="checkbox"/> Shoulder/Arm/Leg
<input type="checkbox"/> Heart/Lung	<input type="checkbox"/> Abdominal
<input type="checkbox"/> Cancer (any type)	<input type="checkbox"/> Other (_____)
<input type="checkbox"/> Head/Brain	<input type="checkbox"/> Other (_____)

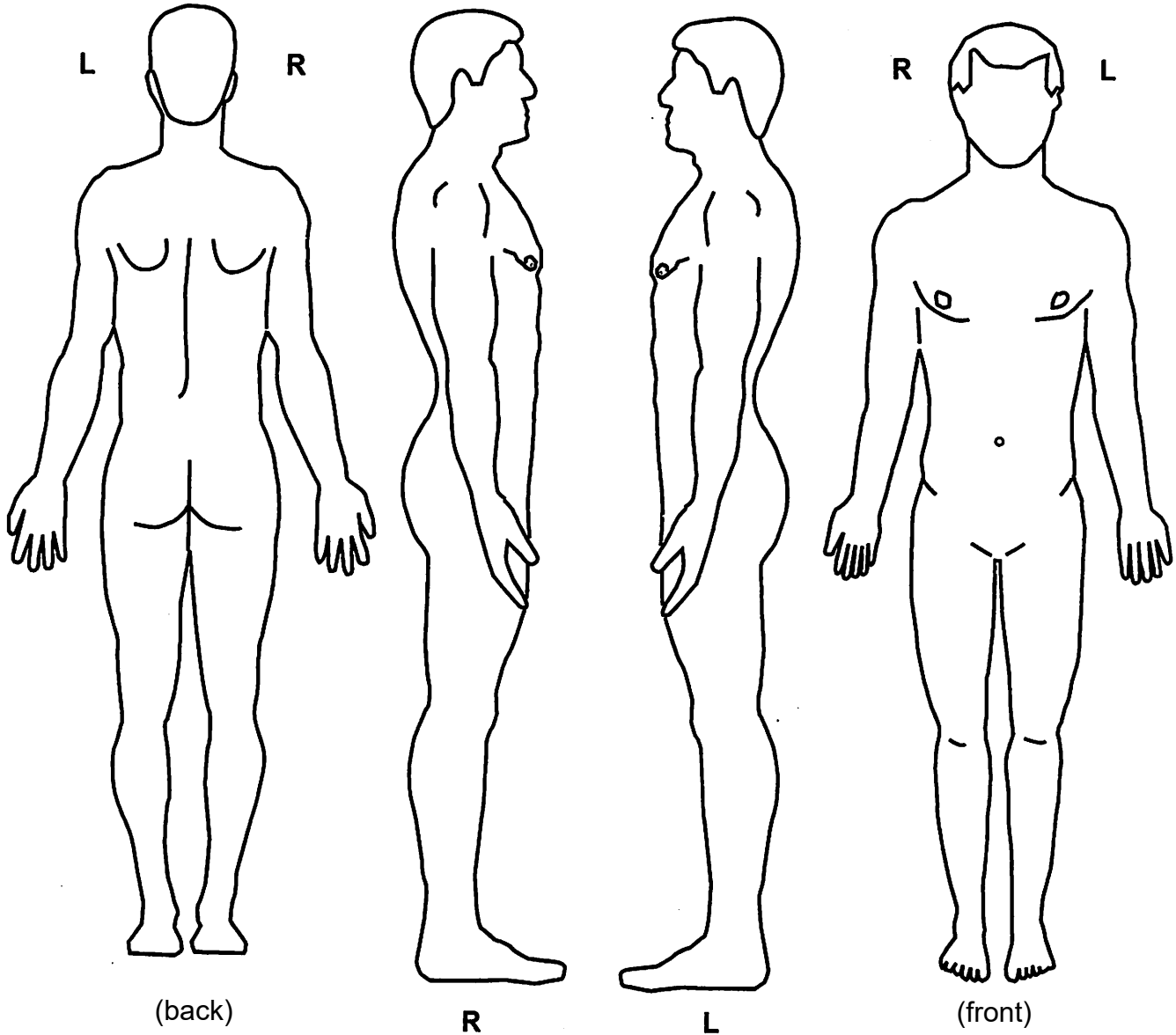
RECENT OR CURRENT SYMPTOMS OTHER THAN CHIEF COMPLAINT

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
<input type="checkbox"/> Headaches		<input type="checkbox"/> Upper Back Pain, Soreness, Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, Tingling		<input type="checkbox"/> Other	

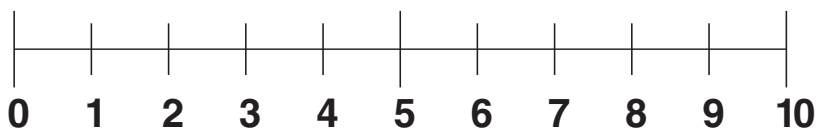
Form 1300

PAIN DRAWING

Name: _____ Date: _____



Mark as follows: A (Ache) B (Burning) N (Numbness) P (Pins & Needles)
S (Stabbing) O (Other - Describe _____)



- New Pain
- Reinjury or Aggravation
- Continuing Care

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 _____

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

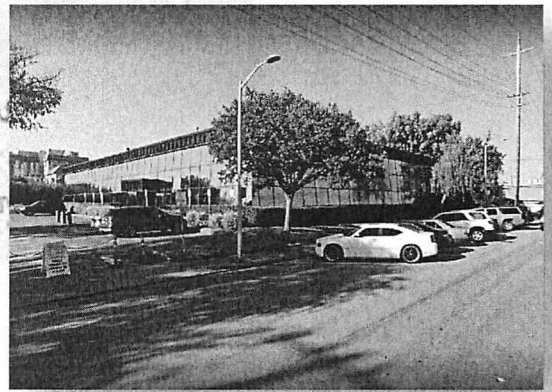
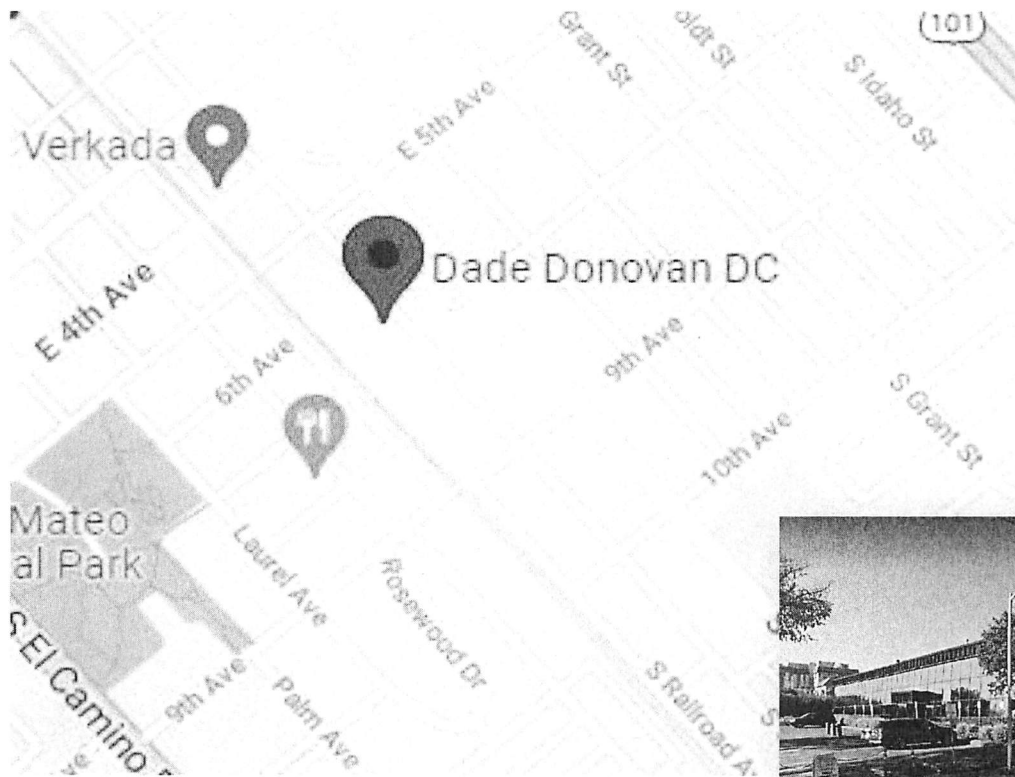
Signature of Patient or Representative

Relationship of Patient Representative

Date Signed

Doctors Signature

Translated or read by



Dade Donovan, DC

700 S. Claremont, Suite 111

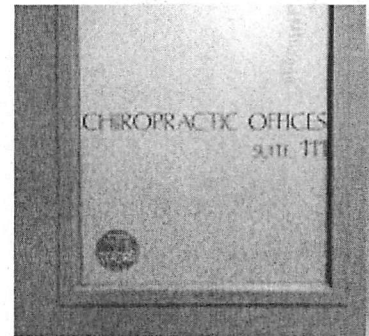
San Mateo, CA 94402

(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.