Doholis Chiropractic Confidential Patient Information

Date _____ SS# _____

Name _____ Phone # _____

Local Address _____ City/State/Zip _____

Other Address _____ City/State/Zip _____

Age _____ Birth Date ____ / ____ / ____ Marital Status: S M W D How Many Children _____

Occupation _____ Employer _____ Work Phone# _____

Work Address _____ City/State/Zip _____

Name of Spouse _____ Occupation _____ Employer _____

Work Address _____ City/State/Zip _____ Phone# _____

Who referred you to our office? _____

List present complaints, injuries and duration and when specifically the symptoms or pain began:

1. _____

_____

2. _____

_____

Brief remarks and details of any recent related accident:

_____

_____

_____

_____

Are your symptoms:

❑ getting worse, ❑ getting better, or ❑ staying the same?

List any doctors consulted for present complaints and injuries:

Name _____ Specialty _____

Address _____

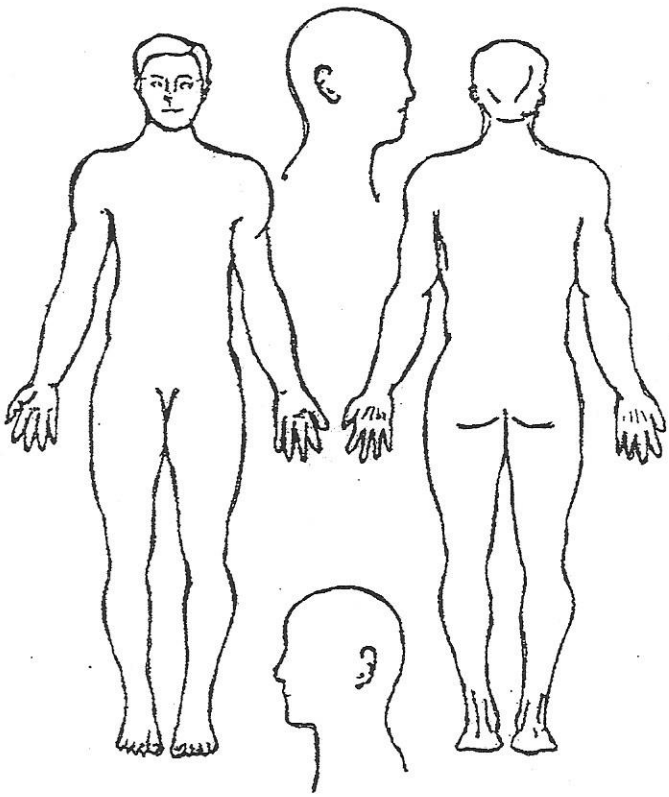
Consulted from _____ to _____

Name _____ Specialty _____

Address _____

Consulted from _____ to _____

Please mark your areas of pain on the figures below:



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How bad is your pain (0 being tolerable to 10 untolerable)

Dr. Stephen Doholis — Doholis Chiropractic — (602) 224-5141

Doholis Chiropractic Patient Past Health History

What surgeries have you had and/or fractures or broken bones, etc.? (Type, When, Doctor, Remarks)

_____

_____

List former serious accidents, injuries and/or falls: (Auto, Work, Home, Leisure, Other) (What, When, Symptoms, Treatment, Results)

_____

_____

List medications and/or diet supplements you take: (What, Frequency, Doctor(s), Side Effects, How Long Taken, Remarks)

_____

_____

Do you wear orthotics, heel or sole lifts, in your shoes? _____

Occupational (Please circle appropriate answer and give details below)

I Spend the Day — Seated / Standing Work Bench / Desk Counter / Other

Job Involves — Lifting (how much) ____ / Bending / Stooping / Twisting / Turning / Carrying / Walking / Standing / Other

Chair — Executive / Steno / Bench / Stool / Folding / Other_____

Shoes — High Heels / Boots / Other_____

Do any work activities aggravate your present main complaints? Describe: _____

Comments: _____

_____

Leisure

Sedentary Activities — TV / Reading / Card Games / Sewing / Other (circle all applicable and describe how long) _____

_____

Strenuous Activities — Sports / Exercise (type, frequency, length of time) Have you had to discontinue any activities? _____

Describe:_____

How would you grade your general stress level? ❑ No Stress ❑ Minimal Stress ❑ Moderate Stress ❑ Greatly Stressed

Physical activity at work: ❑ Sedentary more than 50% of workday ❑ Light manual labor ❑ Manual labor ❑ Heavy manual labor

General physical activity: ❑ No regular program ❑ Light exercise program ❑ Strenuous exercise program

X-Ray Confirmation: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signed: _____

Consent to Treat a Minor Child: I hereby authorize this office to administer chiropractic as deemed necessary to my child.

Signed: _____ (Parent / Legal Guardian)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

Information Taken By: _____ *Date:* _____

Doholis Chiropractic Patient Information

Name: _____ Date: _____

Please check off any of the following symptoms you have experienced:

❑ Headaches	❑ Dizziness	❑ Light Bothers Eyes
❑ Neck Pain	❑ Head Seems Too Heavy	❑ Loss of Memory
❑ Neck Stiff	❑ Pins/Needles in Arms	❑ Ears Ring
❑ Sleeping Problems	❑ Pins/Needles in Legs	❑ Face Flushed
❑ Back Pain	❑ Numbness in Fingers	❑ Buzzing in Ears
❑ Nervousness	❑ Numbness in Toes	❑ Loss of Balance
❑ Tension	❑ Shortness of Breath	❑ Fainting
❑ Irritability	❑ Fatigue	❑ Loss of Smell
❑ Chest Pain	❑ Depression	❑ Loss of Taste
❑ Diarrhea	❑ Stomach Upset	❑ Fever
❑ Feet Cold	❑ Constipation	❑ _____
❑ Hands Cold	❑ Cold Sweats	❑ _____

1. Does this cause you to be:

- ❑ Moody
- ❑ Irritable
- ❑ Interrupt Sleep
- ❑ Restricted on Daily Activities

2. Does this affect your work:

- ❑ Decision Making
- ❑ Poor Attitude
- ❑ Decreased Productivity
- ❑ Exhausted at End of Day
- ❑ Unable to Work Long Hours

3. Does this affect your life:

- ❑ Lose Patience with Spouse or Children
- ❑ Restricted Household Duties
- ❑ Hinders Ability to Exercise or Participate in Sports

A. How long have you noticed this? Weeks _____ Months _____ Years _____

B. Would you like to find out what could be causing your problem? ❑ Yes ❑ No

ACCIDENT REPORT

Name _____ Date of Accident _____ Time of accident _____ am/pm

Type of injury: auto - work injury - fall - other _____

Where did accident happen, in detail _____

_____

Did weather (ice, snow, rain or lighting, etc) play any part in accident? _____

Describe your symptoms in detail: **(circle all that apply)**

1) GENERAL SYMPTOMS:

nervousness, irritability, fatigue, depression, loss of sleep, tension, PMS, Jaw pain

2) HEAD:

headache: ☐ mild ☐ moderate ☐ severe

how often _____ times per ☐ day ☐ week ☐ month

are they ☐ sharp ☐ dull ☐ constant ☐ intermittent

where located ☐ back of head ☐ forehead ☐ temples ☐ right side ☐ left side ☐ behind eyes

Light headed, memory loss, blurred vision, double vision, Sensitivity to light, loss of balance, hearing loss, ringing in ears

3) NECK:

pain: ☐ left side ☐ right side ☐ both ☐ mild ☐ moderate ☐ severe

increased by: forward movement, backward movement, rotation of head (right/left), bending of neck (right/left)

stiffness, muscle spasm, grinding/grating sounds

4) SHOULDERS:

pain in joint	☐ left	☐ right	☐ both
pain across shoulder	☐ left	☐ right	☐ both
limitation of movement	☐ left	☐ right	☐ both
tension	☐ left	☐ right	☐ both

5) ARMS

upper arm

pain	☐ left	☐ right	☐ both
pins & needles	☐ left	☐ right	☐ both
numbness	☐ left	☐ right	☐ both
elbow pain	☐ left	☐ right	☐ both

forearm

pain	☐ left	☐ right	☐ both
pins & needles	☐ left	☐ right	☐ both
numbness	☐ left	☐ right	☐ both

6) HANDS:

wrist pain ☐ left ☐ right ☐ both

hand

pain	☐ left	☐ right	☐ both
pins & needles	☐ left	☐ right	☐ both
numbness	☐ left	☐ right	☐ both

7) MIDBACK:

pain ☐ left ☐ right ☐ both ☐ mild ☐ moderate ☐ severe

spasm ☐ left ☐ right ☐ both ☐ mild ☐ moderate ☐ severe

8) CHEST:

chest pain ☐ left ☐ right ☐ both ☐ mild ☐ moderate ☐ severe

rib pain ☐ left ☐ right ☐ both

shortness of breath

irregular heartbeat

9) ABDOMINAL SYMPTOMS:

pain ☐ left ☐ right ☐ both

nervous stomach, nausea, gas, constipation, diarrhea, heartburn, indigestion, loss of appetite

10)LOWBACK:

pain	☐ left	☐ right	☐ both
spasm	☐ left	☐ right	☐ both

11)HIPS AND LEGS:

pain in buttocks ☐ left ☐ right ☐ both ☐ mild ☐ moderate ☐ severe

pain in hip(s) ☐ left ☐ right ☐ both ☐ mild ☐ moderate ☐ severe

pain down leg(s) ☐ left ☐ right ☐ both ☐ mild ☐ moderate ☐ severe

knee pain ☐ left ☐ right ☐ both ☐ mild ☐ moderate ☐ severe

leg cramp ☐ left ☐ right ☐ both

12)FEET:

ankle pain/swelling ☐ left ☐ right ☐ both

foot pain/cramps/ numbness/swelling ☐ left ☐ right ☐ both

Are your symptoms (1) getting worse, (2) improving, (3) same?

Have you seen another doctor for these symptoms? _____ If so, name and address _____

_____ phone _____

Did you have any of these symptoms prior to this injury? _____ If so, please explain _____

_____

Have you had previous injury to the presently injured area? _____ If yes, when _____

Describe previous injury _____

_____ Doctor consulted _____

Time missed from work for previous injury _____

For present injury, have you missed any work? _____ If yes, dates missed _____

Dates of limited work _____ Date returned to full work _____

Were you capable of working on an equal basis prior to this present injury? _____

Are you right or left handed (circle one)? If married, is your spouse employed? Yes / no

If the present injury was due to an **auto accident**, were you the driver, passenger front, passenger back, or pedestrian?

other _____

Were you wearing seatbelt?

Type of vehicle: auto, truck, van, motorcycle, motorhome, bicycle (other _____)

How accident occurred: A) struck by another vehicle B) struck another vehicle C) struck a stationary object

D) other _____

Where was your vehicle hit? A)front B) rear C) rt side D) lft side E) right front F) lft front G) right rear H) left rear

Your approximate speed _____ MPH Other vehicle's approximate speed _____ MPH

What occurred at moment of impact? (circle as many as apply)

tensed body for impact	neck whipped forward & back	spine torqued and twisted	thrown over seat
thrown from vehicle	pinned in vehicle	thrown from side to side	cut and bruised

Did you strike your ...

head	(against dash, windshield, steering wheel, right door, left door, seat frame, other)
shoulder	lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)
arm	lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)
elbow	lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)
wrist	lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)
hip	lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)
knee	lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)
ankle	lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)

Where you rendered unconscious? Yes/no Did you receive medical attention at scene? _____

Where did you go immediately following accident? Hospital - home - doctor - this office - resumed regular activities

Comments

_____

_____

_____

By signing below, I acknowledge that the information given above is true to the best of my knowledge.

_____ _____

DOHOLIS CHIROPRACTIC
Stephen J. Doholis, D.C.

4531 N. 16th St. # 110

Phoenix, AZ. 85016

(602) 224-5141

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, n me (or on the patient named below from whom I am responsible) by Dr. Doholis, Chiropractor, and/or any licensed doctor or chiropractic associate with or working as a back-up for Dr. Doholis.

I understand that result of treatment are not guaranteed. I understand and am informed that, as in the practice of medicine, In the practice of chiropractic there are some risks to treatment, including but not limited to fracture, disc injuries, stokes, dislocations and strains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interest.

I have read, or had read to me, above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to above named procedures. This consent form is intended to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

To be completed by patient or guardian/patient representative:

Print patient's name:_____

Signature of patient:_____

Date signed: _____

Print name of guardian or patient representative:_____

Witnessed by: _____

DOHOLIS CHIROPRACTIC
Stephen J. Doholis, D.C.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____Insurance company to: Pay by check made out and mailed directly to:

Stephen J. Doholis, D.C. &/or Doholis Chiropractic

4531 N. 16th St. #110

Phoenix, AZ. 85016

OR- if my current policy prohibits direct payment of doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Stephen J. Doholis, D.C. &/or Doholis Chiropractic

4531 N. 16th St. #110

Phoenix, AZ. 85016

the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, and payment toward the total charges for Professional Services Rendered by Doholis Chiropractic, the payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner, any balance of said Professional Service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective as the original.

I also authorize Stephen J. Doholis D.C., to release any information pertinent to my case to any insurance company, adjustor, attorney involved in the case.

Dated at _____this_____ day of_____ 20 _____

_____

Signature of Policyholder

_____

Signature if Claimant if other than Policyholder

DOHOLIS CHIROPRACTIC
Stephen J. Doholis, D.C.

4531 N. 16th St. # 110

Phoenix, AZ. 85016

(602) 224-5141

RE: Medical Reports & Doctor's Lien

I do hereby authorize Stephen J. Doholis, D.C. to furnish you, my attorney with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said Doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said Doctor for all of the medical bills submitted by him for services rendered me and that for all medical bills submitted by him for services rendered me and that this agreement is made solely for said Doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent of any settlement, judgment or verdict by which I may recover a fee.

A fee of 1 1/2% per month will be charged on all outstanding balances, 6 months beginning from the date of the final discharge of the patient.

Please acknowledge this letter by signing below and returning to the Doctor's office. I have been advised that if my attorney does not wish to cooperate protecting the Doctor's interest, the Doctor will not await payment but will require me to make payment of a current basis.

Dated:_____ _____

Patients Signature

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from the settlement, judgment or verdict as may be necessary to adequately protect said Doctor above named.

Date:_____ _____

Attorney's Signature

NOTICE OF PRIVACY POLICIES

This notice describes the health information about you that may be listed and disclosed, and how you can get access to your health information. This is a required Privacy Regulation resulting for the Health Insurance Portability Act of 1966 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information, and to provide a copy of this information to you.

We may use ans disclose your health information in the following ways:

1. Physicians and staff may use or disclose your health information in order to treat you or to assist others in your treatment. We may also disclose your health information to others who may assist you in your care, such as spouse, parents, and children.
2. Our practice may use your health information to bill and collect payments, including your insurer or any third parties that may be responsible for such costs. We may also use your health information to bill you directly for services and items.
3. Our practice will use and disclose your health information if we are required by law.
4. We may call you for appointment reminder purposes. Please advise us if you do not want us to call and leave appointment reminder messages at your home, answering machine or with co-workers at you place of work. We may also use a sign-in-sheet at our front desk. We will make all efforts to keep this information confidential.

Your rights concerning your health information:

1. You can request that our practice communicate with you about your health and related issues in a particular manner. We will do our best to accommodate all reasonable requests.
2. You can request that we restrict our use of your health information for treatment, payment or health care operations, as well as the release of this information only to certain individuals. We are not however, required to agree to your records in some circumstance.
3. You have the right to inspect and obtain a copy of your medical and billing records. You must submit your records in writing to your physician. You may ask us to amend your health information if you believe it is incorrect or incomplete. To request an amendment, you must supply us with a reason to support your request.
4. If you believe your privacy rights have been violated you may file a complaint with our office or with the Secretary of the Department of Health & Human Services. To file a complaint with our practice or if you have any questions about this policy notice, please contact your physician's secretary at (602)244-5141.

We have supplied you with our Notice of Privacy Practice. You will be asked to place your signature in your chart indicating that you have read, understood and agreed to this policy. A copy of this policy may be obtained from the receptionist at the front desk.

PATIENT SIGNATURE _____ DATE: _____

WITNESS: _____ DATE: _____