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 do cover chiropractic care; however we cannot make any specific representations that yours does. Please note that insurance does often change throughout the policy year, often without notice.

Please remember that you are ultimately responsible for any 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.

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 some tasks.

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: ________________ Your 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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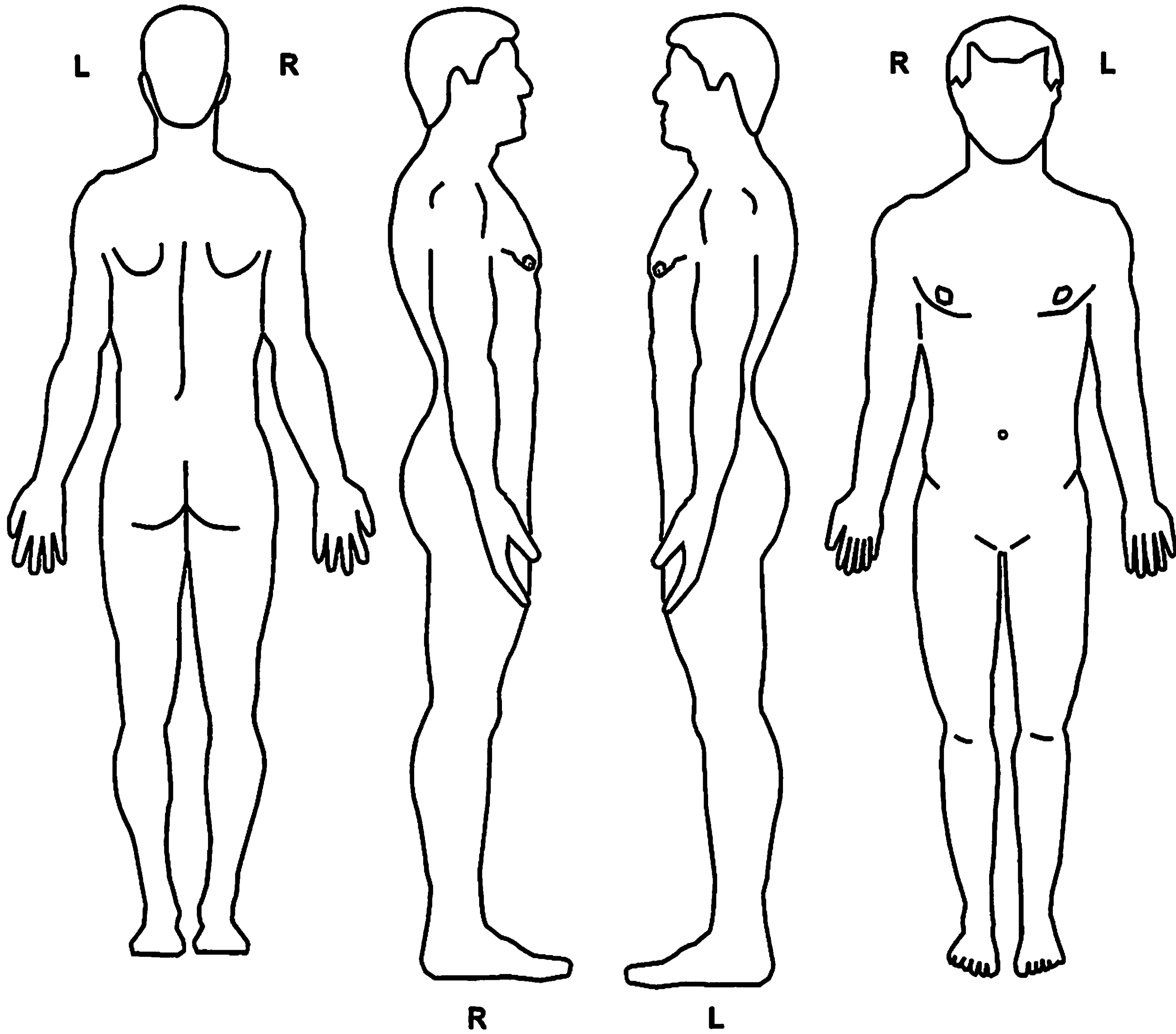
PAIN DRAWING

Name ____ Date ____________



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

Financial Agreement for services rendered.

It is our policy that payment be made at the time of services are rendered, unless otherwise agreed. It is your responsibility to make payments in order to keep you account current. Additionally, it is the policy of this office not to let patient balances exceed $200.

Initial Examination Fee $115
Chiropractic Adjustment $60
Active Release Technique (ART) $60
Chiropractic Adjustment and ART during same office visit $85
Subsequent Re-Examination $35 to $95 (as necessary, to evaluate new conditions and/or significant re-injuries)
Modalities (Ultrasound, Muscle Stimulation, Traction) $20

Important Office policies:

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.

Notes:____
____
____

______________________ ______________________
Patient Signature Date

______________________ ______________________
Office Staff Date

MAPQUEST.

Notes

Map of 700 S Claremont St
Ste 111
San Mateo, CA 94402-1447

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ART Active Release Techniques

DADE W. DONOVAN DC

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T 650-348-4233
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CHIROPRACTIC, SOFT-TISSUE TECHNIQUES, THERAPEUTIC EXERCISE