Doroski Chiropractic Neurology

3122 Golansky Blvd., Suite 102
Woodbridge, Virginia 22102

Dr. Scott Doroski, DACNB, DC, BS Phone: (703) 730-9588 Fax: (703) 897-4261

Last:_____ **First:**_____ **Middle:** _____

Date of Birth:_____ **Age:**_____ **Sex M F** **Social Security #**_____ - ____ - _____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Phone:(_____**)**_____ **Work Phone:(**_____**)**_____

How did your hear about us? _____ **Marital Status: S / M / O**

Employer:_____

Employer's Address:_____

Occupation_____

Was this injury related to: Work / Auto / Other_____ **Date of Injury:**_____

Name of Attorney:_____

I UNDERSTAND AND AGREE THAT ALL FEES FOR PROFESSIONAL SERVICES RENDERED IN MY BEHALF ARE MY RESPONSIBILITY AND THAT I AGREE TO PAY FOR ALL MY SERVICES AND DEDUCTABLES UNPAID BY MY INSURANCE.

Signed:_____ **Date:**_____

Insurance Carrier:_____ **Phone:(**_____**)**_____

Address_____

City:_____ **State:**_____ **Zip:**_____

Policy#:_____ **Group#:**_____

PLEASE COMPLETE THIS INFORMATION IF THE PATIENT IS NOT THE INSURED

Insured's Name:_____ **Phone:(**_____**)**_____

Insured's Address:_____

Social Security #_____ - ____ - _____ **Birth Date:**_____ **ID or Group#:**_____

Patient's relationship to Insured:_____

Patient Name:_____ **Admittance Date:**_____

Present Complaint:_____

_____

Please describe the character of your current pain (all that apply): □Sharp/Stabbing □Aches □Dull □Soreness □Weakness □Throbbing □Numbness □Shooting □Burning □Tingling □Gripping

How often are these complaints present? □Constant (76-100%) □Frequent (51-75%) □Occasional (26-50%) □Intermittent (25-0%

How bad is your pain? No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Since your problem began is the pain? □Increasing □Decreasing □Not Changing

When did your problem begin? _____

Did your problem begin: □Immediately after a specific incident □Multiple incidents □Gradual over time

Describe how your problem began:_____

_____

What treatment have you received for this problem? □Surgery □Spinal injections □Physical therapy □Back support □Medications □Other_____ □None

Were you previously treated for a different occurrence of the same condition? □Yes □No
If Yes, by: □Chiropractor □MD □Therapist □Other_____

What makes your problem better? □Nothing □Lying down □Walking □Standing □Sitting □Movement □Inactivity □Other_____

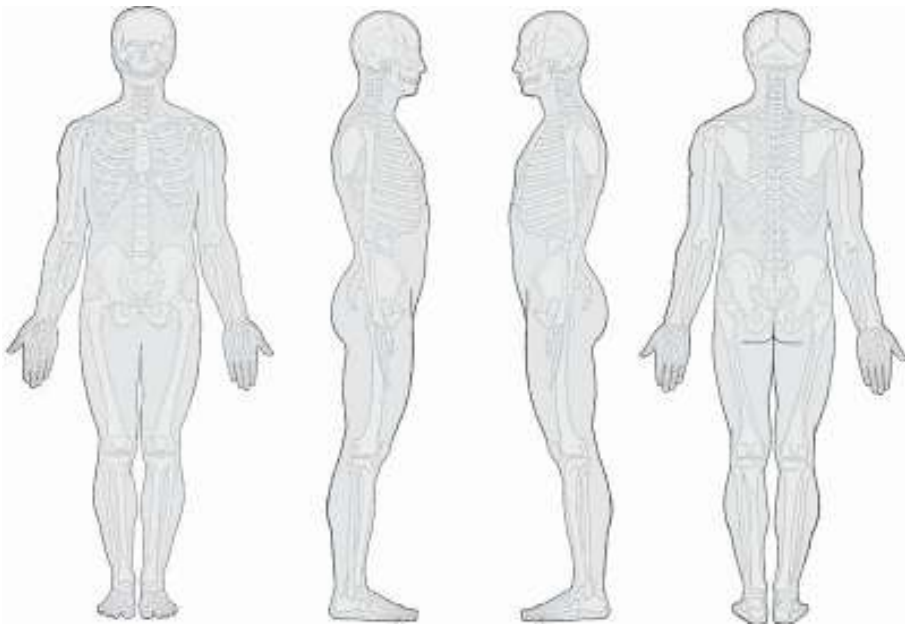
What makes your problem worse? □Nothing □Lying down □Walking □Standing □Sitting □Movement □Inactivity □Other_____

Physical activity at work: □Sitting >50% □Light manual Labor □Manual labor □Heavy manual labor

General physical activity: □No regular exercise □Light exercise program □Heavy exercise program

Are your complaints affecting your ability to work or otherwise be active?
□No effect
□Some physical restriction
□Need assistance with common everyday tasks
□Need assistance often
□Have a significant inability to function without assistance
□Totally disabled (cannot care for self)

Mark an X on the picture where you have pain or other symptoms including pain, numbness, tingling, bruises and aches.



HEALTH HISTORY

Are you taking any of the medications?

□Nerve pills □Pain Killers □Muscle relaxers □Stimulants □Blood thinners □Tranquilizers
□Insulin □Aspirin □Other_____

Have you ever had any of the following diseases/medical condition(s)?

□Heart attack/stroke
□Congenital heart defect
□Alcohol/drug abuse
□HIV+/Aids
□Frequent neck pain
□High/low blood pressure
□Severe/frequent headaches
□Fainting/seizures/epilepsy
□Diabetes
□Lower back problems
□Hepatitis
□Anemia
□Arthritis
□Heart surgery/pacemaker
□Mitral valve prolapse
□Shingles
□Emphysema/glaucoma
□Psychiatric problems
□Kidney problems
□Sinus problems
□Difficulty breathing
□Artificial bones/joints
□Heart murmur
□Cancer
□Ulcers/colitis
□Tuberculosis

List any serious medical conditions you have ever had:_____

_____

List anything you may be allergic to:_____

_____

List any previous surgeries:_____

_____

List any past accidents:_____

_____

Do you smoke? □No □Yes If yes, how many a day?_____ How long?_____
Are you wearing: □Heel lifts □Sole lifts □Inner soles □Arch supports
What is the age of your mattress?_____ Is it comfortable? □No □Yes

For Women Only…
Are you taking Birth Control? □No □Yes
Are you pregnant? □No □Yes If yes, how long?_____ Nursing? □No □Yes

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AUTHORIZATION FOR AND CONSENT TO MANIPULATION OR SPECIAL PROCEDURES

PATIENT'S NAME: _____

DOCTOR:_____

THE CLINIC MAINTAINS PERSONNEL AND FACILITIES TO ASSIST YOUR DOCTOR(S) IN THE PERFORMANCE OF VARIOUS MANIPULATIVE PROCEDURES AND OTHER SPECIAL DIAGNOSTIC AND THERAPEUTIC PROCEDURES. THESE MANIPULATIVE AND ANCILLARY PROCEDURES ALL MAY INVOLVE CALCULATED RISKS OF COMPLICATIONS, INJURY, OR EVEN DEATH, FROM BOTH KNOWN AND UNKNOWN CAUSES AND NO WARRANTY OR QUARANTY HAS BEEN MADE AS TO THE RESULT OR CURE. EXCEPT IN EMERGENCY OR EXCEPTIONAL CIRCUMSTANCES, THESE OPERATIONS AND PROCEDURES ARE THEREFORE NOT PERFORMED UPON PATIENTS UNLESS AND UNTIL THE PATIENT HAS HAD AN OPPORTUNITY TO DISCUSS THEM WITH HIS DOCTOR. EACH PATIENT HAS HAD THE RIGHT TO CONSENT TO OR REFUSE ANY PROPOSED PROCEDURE OR THERAPY (BASED ON THE DESCRIPTION OR EXPLANATION RECEIVED).

YOUR DOCTOR(S) HAS DETERMINED THAT THE PROCEDURE OR PROCEDURES LISTED BELOW MAY BE BENEFICIAL IN THE DIAGNOSIS OR TREATMENT OF YOUR CONDITION. UPON YOUR AUTHORIZATION AND CONSENT SUCH OPERATIONS OR PROCEDURES WILL BE PERFORMED FOR YOU BY YOUR DOCTOR.

YOUR SIGNATURE OPPOSITE THE PROCEDURE(S) LISTED BELOW CONSTITUTES YOUR ACKNOWLEDGMENT(S) THAT:

(1) YOU HAVE READ AND AGREED TO THE FORGOING;

(2) THE PROCEDURE(S) AND POSSIBLE ALTERNATE MEANS OF THERAPY HAVE BEEN ADEQUATELY EXPLAINED TO YOU BY YOUR DOCTOR AND THAT YOU HAVE ALL THE INFORMATION YOU DESIRE;

(3) YOU AUTHORIZE AND CONSENT TO THE PERFORMANCE OF PROCEDURE(S) OR SPECIFIED TEST(S);

(4) YOU CONSENT TO THE PERFORMANCE OF PROCEDURE(S) AND TEST(S) IN ADDITION TO OR DIFFERENT FROM THOSE SPECIFIED BELOW WHETHER OR NOT ARISING FROM PRESENTLY UNFORESEEN CONDITIONS WHICH YOUR DOCTOR(S) MAY CONSIDER NECESSARY OR ADVISABLE IN THE COURSE OF THE PROCEDURE(S) SPECIFIED BELOW; AND

(5) NO GUARANTEE OF CURE HAS BEEN PROMISED TO YOU.

PROCEDURE(S):_____

_____

PATIENT'S SIGNATURE:_____ DATE:_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices, and have been advised of how health information, about me, may be used and disclosed by Doroski Chiropractic, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV – related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

_____
Signature of Patient or Representative

_____ _____
Print Name of Patient or Representative **Date**

_____
Description of Representative's Authority

_____ _____
Doroski Chiropractic Representative **Date**

_____
Print Name