Dr. Douglas Drobbin, D.C.
1298 Newbridge Road
North Bellmore, New York 11710
Tel: (516) 379-8500
Fax: (516) 546-0077
drobbinchiropractic@gmail.com

Name: _____ Date:_____

Address: _____City: _____State:_____ Zip: _____

SS#:_____ Date of Birth: _____ Age: _____

Home phone: _____Cell:_____ SMS Text ☐ Work:_____

Referred by: _____ Emergency Contact Name & Number: _____

Married: _____ Single: _____ Divorced:_____ Number of Children:_____

Do other family members receive chiropractic care? Yes_____ No_____ Who? _____

Occupation: _____ Years at present job?_____

Business Address: _____

Email: _____

Do you have health insurance? Yes_____ No_____ Name of Insurance company_____

Previous chiropractic care? Yes_____ No_____ When? _____ Dr's name:_____

Previous spinal X-rays? Yes_____ No_____ When?_____ Reason_____

Did an injury occur: On the Job/ Auto Accident/ Other_____

Briefly describe present complaint: _____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection form the insurance company except, from Medicaid and workman's compensation, and that any amount authorized to be paid directly to the doctor's 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, any fees for professional services rendered me will be immediately due and payable.

Patients signature:_____ Date:_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Drobbin Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill or to conduct health care operations of Drobbin Chiropractic. I understand that diagnosis or treatment of me by Drobbin Chiropractic may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Drobbin Chiropractic is not required to agree to the restriction that I may request. However, if Drobbin Chiropractic agrees to a restriction that I request, the restriction is binding on Drobbin Chiropractic and Dr. Douglas Drobbin.

I have the right to revoke this consent, in writing, at any time, except to the extent that Drobbin Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Drobbin Chiropractic's Notice of Privacy Practices prior to signing this document. The Drobbin Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Drobbin Chiropractic. This Notice of Privacy Practices also describes my rights and the Drobbin Chiropractic's duties with respect to my protected health information.

Drobbin Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by Drobbin Chiropractic's by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustment are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
have read and fully understand the above Informed Consent and hereby grand permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle

_____

_____	_____
Signature	Date

Name _____ Date_____

Please check any of the following symptoms of poor health, which you have or have had previously. In order to provide necessary chiropractic care we need to know all the facts related to your health. This is a Confidential Health Report.

__Headaches
__Neck Pain
__Mid Back Pain
__Low Back Pain
__Pins+Needles in Arms
__Pins+Needles in Legs
__Numbness in Fingers
__Numbness in Toes
__Pain in Arms
__Pain in Legs
__Pain between Shoulders
__Cold Hands
__Cold Feet
__Neck Stiff
__Back Stiff
__Convulsions
__Nervousness
__Tension
__Irritability
__Chest Pain
__Dizziness
__Face Flushed
__Shortness of Breath
__Fatigue
__Depression
__Eyes Sensitive to Light
__Loss of Memory
__Ringing in Ears
__Fainting
__Loss of Taste
__Loss of Smell
__Diarrhea
__Constipation
__Stomach Upset
__Poor Digestion
__Cold Sweats
__Night Sweats
__Loss of Balance
__Chronic Cough

L / R Shoulder
L / R Hip
L / R Elbow
L / R Knee
L / R Wrist
L / R Ankle

Your Current Problem - What are your current symptoms?

1._____
2 _____
3._____
4._____

Habits:

☐ Alcohol - How often?_____
☐ Coffee - Cups/day?_____
☐ Tobacco - Packs/day? _____

Have you ever?

Yes	No	
☐	☐	Been knocked unconscious?
☐	☐	Used crutches or other support?
☐	☐	Been treated for a spine problem?
☐	☐	Been treated for any nerve disorder?
☐	☐	Had a fractured/broken bone?
☐	☐	Had surgery?
☐	☐	Been hospitalized for anything other than surgery?

What level of intensity would you rate your pain? (10 = severe) **1 2 3 4 5 6 7 8 9 10**

What is the frequency of your symptoms? **Occasional / Episodic / Intermittent / Frequent / Constant**

Do your symptoms affect personal life? (hobbies, sports, etc.) _____

Do your symptoms affect your job/occupation? (days missed, inability to stand/lift/drive)_____

How long have your suffered from these symptoms?_____

Have you suffered from these symptoms before? ___Yes ___No

What makes symptoms worse?_____

What makes symptoms better?_____

What home remedies have you tried?_____

Have you been to any other doctor for this type of problem?_____

Answer Yes or No to the following questions.

Yes	No	
☐	☐	Do you sleep 6-8 hours of deep uninterrupted sleep every night?
☐	☐	Do you have at least 1 bowel movement every day?
☐	☐	Do you feel/have bloated, gassy, stomach distress, sour burps, hiatal hernia, or heartburn?
☐	☐	Do you have allergies/sinus/congestion symptoms or asthma?
☐	☐	Do you have frequent/urgent or nighttime urination?
☐	☐	Do you have: arthritis or achy/painful joints?
☐	☐	Do you have: varicose veins or bruise easily?
☐	☐	Are you: tired all the time/wake up tired/sleepy at 3pm?
☐	☐	Do your ankles swell or do you have leg cramps at night?
☐	☐	Do you have low resistance or are you sick often?

Describe your dental health _____

Date of Last: (approximate)

_____Physical Examination
_____Blood Test
_____Urine Test
_____Chest X-Ray
_____Spine X-Ray
_____Dental X-Ray
_____Other_____

Signature _____ Date_____