Donay Life & Wellness Center
330 W. Twain Ave.
Urbana, Ohio 43078
(937)653-5353

Thank you for choosing our office for your chiropractic health and wellness needs. We take pride in what we have to offer our community. It is our pleasure to serve each and every one of our patients with the utmost respect, privacy, and gratitude for graciously choosing our office.

Please answer the following:

How Did You Hear About Us? (Please Mark the Correct One)

- o Are you a Past Patient (Please List) ______________________
- o Friend (Please List) ______________________
- o Family Member (Please List) ______________________
- o Newspaper
- o FaceBook, Twitter, Etc.
- o Google, Bing, Etc.
- o Attorney (Please List) ______________________
- o Family Physician/ Specialist (Please List) ______________________

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some. risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: ____________________

Signature of Patient: ____________________

Name Printed of Guardian/Parental and Relationship to Patient: ____________________

Guardian/Parental Signature: ____________________

Date: ____________________

Doctor of Chiropractic Name: ____________________

Signature of Doctor of Chiropractic: ____________________

Date: ____________________

Pregnancy Release

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

____

Signature Date

Patient Information

NP ReAct MM MCR MCaid BWC PI CASH

____ NO CHANGES

Basic Information

Name:______________________ M / F Date:__________
Current address: ______________________
City: ______________ State: ________ ZIP:________
Telephone #:__________ Cell Phone #: __________ Work Phone #: __________
Email:__________ Present employment/Occupation: __________
Date of Birth:__________ Age: ______ Soc. Sec. Number: __________
Marriage Status: Single Married Divorced Minor Separated Widowed
Present Insurance __________

Please present a copy of any new insurance cards

____ NO CHANGES

Release of Information

Family Physician:	Phone:
Address:	

May we send your health information to this provider? YES NO

Emergency Contact

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

May we leave a message on your answering machine with personal health information?. YES NO

Patient Medical History

___No Changes

A) Please **Mark** all that apply personally to you.
B) Please **Circle** all that apply for your family.

___ Allergies ___ Asthma ___ Heart Disease ___ High Blood Pressure
___ Sinus ___ Skin ___ Arthritis ___Anemia/Bleeding disorders
___Seizures ___Diabetes I or II ___Ear Infections ___Headache/Migraines
___TMJ ___Recent Surgery ___ Recent Illness ___Broken bones/dislocation
___ Cancer ___ Stroke ___ Auto Accident ___ Other: __________

Do you smoke? ___ No ___Occasionally ___Moderately ____ Packs per day
Do you drink alcohol? ___No ___Occasionally ___Moderately ____Drinks per week
Do you exercise? ___ No ___Occasionally ___Moderately ___Regularly
Are you Pregnant? No ___ Yes ___ Due Date __________

Please list all your current medications & purpose for medications:

Medication	Reason/purpose
__________	__________
__________	__________
__________	__________

Please list all your surgeries and dates (month & year):

Surgery	Date (month & year)
__________	__________
__________	__________
__________	__________

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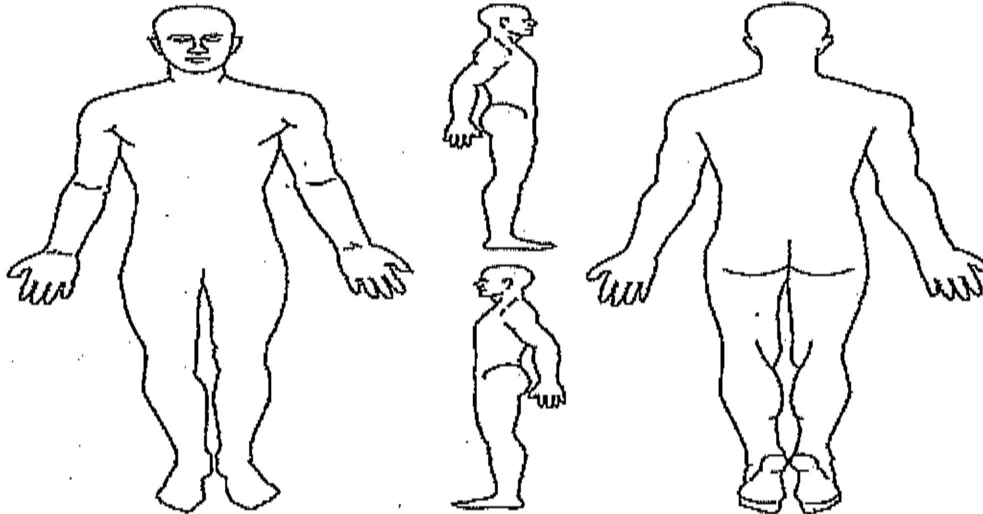
Name:_______________________________ Date: ___________________

Please draw the location of your pain/discomfort on the body.
Use the symbols to represent the type(s) of pain:

D=Dull B= Burning N=Numb
S=Stabbing T=Tingling C=Cramping
P= Pressure Sp= Sharp W= Weakness
➔ = Radiating or Travels



1) Please list your areas of pain/discomfort that are of most concern to you.
2) Mark the most accurate number to describe the pain/discomfort over the last 24 hours
   0=no pain, 10=severe pain
3) Tell us how frequent your pain/discomfort occurs using the following scale:
   0=no pain, 10=constant

Area (1)	Pain Scale (2)	Frequency (3)
1)________________	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2)________________	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3)________________	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4)________________	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
5)________________	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

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PAIN DISABILITY QUESTIONNAIRE

PATIENT NAME: ______________________________ DATE: ____________________

Instructions: Day one please use ○ , 2nd time use △ , 3rd time use □ , and fourth time use X to answer each question

Date: ____________________ Please use ○ to mark your answers Score: ______________
Date: ____________________ Please use △ to mark your answers Score: ______________
Date: ____________________ Please use □ to mark your answers Score: ______________
Date: ____________________ Please use X to mark your answers Score: ______________

. Does your pain interfere with your normal work inside and/or outside the home?
Work Normally — Unable to Work
0 1 2 3 4 5 6 7 8 9 10

. Does your pain interfere with personal care (such as washing, dressing, etc.)?
No interference — Need Help with Care
0 1 2 3 4 5 6 7 8 9 10

. Does your pain interfere with your traveling?
No Interference — Only Travel for Doctors
0 1 2 3 4 5 6 7 8 9 10

. Does your pain affect your ability to sit and/or stand?
Not at all — Unable to Sit/Stand
0 1 2 3 4 5 6 7 8 9 10

. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
Not at all — Cannot do at all
0 1 2 3 4 5 6 7 8 9 10

. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
Not at all — Cannot do at all
0 1 2 3 4 5 6 7 8 9 10

. Does your pain affect your ability to walk or run?
Not at all — Cannot do at all
0 1 2 3 4 5 6 7 8 9 10

. Has your income declined since your pain began?
Not at all — Lost all Income
0 1 2 3 4 5 6 7 8 9 10

. Do you have to take pain medication every day to control your pain?
No medication needed — Medication throughout day
0 1 2 3 4 5 6 7 8 9 10

0. Does your pain force you to see doctors much more often than before your pain began?
Not at all — See doctors weekly
0 1 2 3 4 5 6 7 8 9 10

1. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No Interference — Never see them
0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with recreational activities and hobbies that are important to you?
Not at all — Cannot do at all
0 1 2 3 4 5 6 7 8 9 10

3. Do you need help to complete everyday tasks (including work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 1 2 3 4 5 6 7 8 9 10

4. Do you now feel more depressed, tense, and/or anxious than before your pain began?
Not at all — Severe depression/tension
0 1 2 3 4 5 6 7 8 9 10

5. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?
No problems — Severe problems
0 1 2 3 4 5 6 7 8 9 10

<u>1-70 Mild Grade 1, 71-100 Moderate Grade 2, 101-130 Severe Grade 3, and 131-150 Extreme Grade 4</u>