Dr. Miravone Dorough, DC, ND

at Estuary Center for Living & Healing Arts

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Personal Information

Name _____ Today's Date _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Date of Birth _____ Age _____

_____

Social Security # _____ Height _____ Weight _____

Emergency Contact Relationship _____ Phone _____

_____

Health Insurance Company _____ Member ID _____

Name of Insured _____ Insured's Date of Birth _____

Whom may we thank for referring you to our office? _____

Birth History

Was baby born at term? ____Yes _____No Weeks: _____

Was baby's first feeding breast milk? ____Yes _____No

Prenatal or neonatal complications? ____Yes _____No

NICU stay required? ____Yes _____No If yes, why? _____

During pregnancy did mother use tobacco, alcohol or drugs? ____Yes _____No

APGAR score: _____

Vaginal or Caesarean Birth (Circle One)

Birth weight: _____ Birth length: _____

Newborn hearing screening normal? _____

Medial & Social History

Your relationship to the patient: _____

Present health concerns: _____

Any other children in the home? _____ Ages of children_____

Allergies: (Food, drugs, pets, etc.) _____

Is there pets at home (list): _____

Medicines/vitamins: _____

Has child ever received immunizations? _____Y _____N

Has the child ever received Chiropractic care? _____Y _____N Doctor: _____

Approximately how long were you under care? _____ Date of last visit? _____

Why did you stop? _____

Social/Lifestyle

Did/does your child attend school/preschool? ____Yes _____No

Current grade _____

Any concerns about school performance? _____
_____

Has your child had any unusual feeding/dietary problems? _____

Sports/exercise: Type: _____

How long/often? _____

Has child recently traveled outside of the country? ____Yes _____No

Where/When: _____

Any major life changes in your child's life? _____
_____

Sleep

Hours per night _____ Naps: _____

Sleep problems? _____

Diet (Describe A Typical Days Diet)

Breakfast:

Lunch:

Dinner:

Snacks:

Desserts (How often):

Fluids (Include type and amount):_____

How often do you eat out? _____

Do you buy Organic Foods? ____Yes _____No

How much of the following would be found in the foods you eat on a daily basis?

Synthetic sugars _____
Preservatives _____
Colors/Dyes _____
Synthetic chemicals _____

Confidential Health History

The following items may relate to your current condition. In the space in front of each item, place a P if you PRESENTLY have the problem and an H if you previously HAD the problem. Leave space blank if you NEVER had the problem.

FAMILY HISTORY
_____ Alcoholism
_____ Asthma
_____ Bleeding Disorder
_____ Cancer
_____ Diabetes
_____ Depression/Suicide
_____ High Blood Pressure
_____ High Cholesterol
_____ Heart Disease
_____ Kidney Disease
_____ Muscle, Bone or Nerve Disease
_____ Stroke
_____ Thyroid Disease/Goiter
_____ Tuberculosis
_____ Other

GASTROINTESTINAL
_____ Poor Appetite
_____ Black or Bloody Stools
_____ Bloating/Gas
_____ Colitis/IBS
_____ Constipation
_____ Diarrhea
_____ Excessive Hunger or Thirst
_____ Hemorrhoids
_____ Hernia
_____ Indigestion
_____ Liver Disease
_____ Loss of Bowel Control
_____ Nausea
_____ Reflux
_____ Stomach Pain
_____ Liver Problems
_____ Ulcer
_____ Vomiting

CARDIOVASCULAR
_____ Chest Pain
_____ Heart Disease
_____ High Blood Pressure
_____ Irregular Heartbeat
_____ Low Blood Pressure
_____ Pacemaker
_____ Poor Circulation
_____ Stroke
_____ Swelling of Ankles
_____ Varicose Veins
_____ Heart/Lung Defect

RESPIRATORY
_____ Asthma
_____ Difficult Breathing
_____ Chronic Cough
_____ COPD
_____ Emphysema
_____ Pneumonia
_____ Tuberculosis
_____ Wheezing

MUSCULOSKELETAL
_____ Spinal Curvature
_____ Arthritis

GENITO-URINARY
_____ Bladder Trouble
_____ Difficulty Starting/Stopping Flow
_____ Frequent Urination
_____ Painful Urination

NEUROLOGIC/MENTAL
_____ Anxiety
_____ Anger/Aggression
_____ Attention Deficit
_____ Psychotic episodes
_____ Tremors
_____ Mental Disorder

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on myself (or on the patient named below for which I am legally responsible) which are recommended by Dr. Miravone Dorough.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with Dr. Miravone Dorough and/or with office personnel, the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature of Patient/Guardian: _____ Date: _____

Signature of Insured (If Different): _____ Date: _____

Privacy Policy (HIPAA)

We are 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. If applicable, we may disclose your health information, as deemed necessary by law, to comply with state Workers' Compensation Laws, in cases of medical emergencies, to aid public health agencies such as the CDC and FDA, Governmental agencies as required by law, law enforcement officials and to comply with a court order, preapproved agencies for purposes of organ donation or research, or to proper authorities as recognized by the state in order to assure public safety. Your rights include the ability to request (only) restriction on certain uses and disclosures, to receive protected information by alternate means or at an alternate location, to have your physician amend your protected health information or file a statement of disagreement with your physician, and to receive an accounting of certain disclosures your physicians have made (if any). A more detailed explanation of these rights and responsibilities is readily available upon request, or at www.hfa.gov/medicaid/hippa.

Signature of Patient/Guardian: _____ Date: _____

Signature of Insured (If Different): _____ Date: _____

Thank you for choosing Dr. Miravone at Estuary Center for Living & Healing Arts!

I look forward to improving your health!