no regigal	The principles		1	CASE	HISTOR	Y				
Name:		111		EVENTAL MICHELL	Age:	Date:	Bro A	Case	Numbe	er:
Address:	VICTAL NEE			4.505	City:	O gradina 1		_ State:		Zip:
Phone:(H)	aga taent - 50 in	(C)		- 194 201 2 BATT	ax:		E-mail:	ne	gliman	AS 024
	th:			Sex: DMDF	Marital Status	S: OS ON	MODE	JW #	of Child	ren:
Occupation	d golfage T.A		Em	ployer:	0.0,0	Telephone	e (Work	:):	5,150	_Ext
Insured's N	ame:		7 78	Phone:	D D Squar	Insure	ed's Da	te of Birt	n:	Section 1
Spouse's N	lame:		45000	A PARTY SEE	Spouse's C	occupation	· ser - C	OPID .	2017	
Spouse's E	mployer:	4	1000	Land Rough	Spouse's T	elephone (	(Work):		erites	ser 0.481
Past Chiro	practic Care:	☐ Yes [	J No V	Vhen?	Doctor's Na	ame:	BATELL IL	1.9	end if he a	Mary Control
Results:	All participations and a	P. 0101		NASCI CHEN - 1 F	Referred by	/:	OLE L	144	ES. A.	
Insurance (	Company:	3 4 4		1,850 0.48 T	Telephone:	SI (08 1009		OC	en in	1957 E
Social Seci	urity Number				Driver's Lic	ense Num	ber:	I TO C	S	tate:
Spouse's Ir	nsurance Cor	mpany:			lelephone:	CARRITAG		- 07 ft	4	
Spouse's S	Social Securit	y Numb	er:	- Strature   001	Spouse's D	Priver's Lic	ense N	umber:_		
Emergency	Contact:	Table Section	rga:	Relations	hip	Ring September	Contac	t Numbe	r	
Are you now Have you re	w or have you etained an atto	ever bee orney?	n disabl	Yes  To Emploed? (Service or W Yes Name & Ad	Vork)? ☐ No ☐ dress:	Yes Whe	n?	3116	Why?_	Res Y
Pain Sympt	toms: 1	ARA LID	F (8)	neith dies	Began-(Mo					
(in order of	2	sea IIII	C	NE extigues 1658	Began-(Mo	/Yr):	Pre	vious Epis	odes:	resid ETF
severity)	3	era III G	14		Began-(Mo					
Tuni a	id is to come	000 E2 000	(T)		i s	Admiration of	SAL	500	artari	. and
Example	2 3 4 5	6 7 6 7 6 7	8 9 1 8 9 1 8 9 1		T-Tin	mbness gling reness	A-A		Left	
☐ Smoking	HABITS Packs/Da		- 0	EXERCISE None Light Activity Moderate Activity	Mother	Diabetes	FAMILY Heart	HISTORY Kidney	Cancer	Other
				Moderate Activity  Active	Father	0				0
☐ Caffeine	Cups/Day	/-		Very Active	Brother,# of:					
				Elite Athlete	Sister,# of:		0			ed of any tolk
	ALL A	VE VOII	HAD	R DO YOU HAVE	ANY OF THE	FOLLOWI				
			HAND IN THE		at the formation control to					tic
□ 541 □ 480	Appendicitis		280	Anemia	□ 429.9 □ 240	Heart Disea Goiter	156	☐ 716 ☐ 345	Arthri Epile	
□ 480	Pneumonia		055	Measles	☐ 487	Influenza		☐ 343 ☐ 319		al Disorder
□ 390 □ 045	Rheumatic Fe		072	Mumps Chicken Pox	D 511	Pleurisy		724.2		
045	Tuberculosis		250	Diabetes	□ 303.9	Alcoholism		□ 690	Ecze	ma
□ 033	Whooping Cor	ugh C	239	Cancer	□ 099	Venereal D	isease	<b>0</b> 42	HIV	Positive
□ 493.9	Asthma		346.9	Migraine Headach	es 054.9	Herpes		□ 340	Multi	ple Sclerosis

Migraine Headaches 054.9 (OVER)

							J		A STATE OF THE PERSON NAMED IN	- 1 10110	ousiy 🛥 r reseriii
Previously Presently			j	1		Never Previously Presently			Never Previously Presently		
Prev	GENER	AL SYMPTOMS	Prev.	GASTRO	D-INTESTINAL	Prev Pres	EYE/EA	R/NOISE/THROAT	Prev Pres	RESPIR	ATORY
000	995.3	Allergy (What)	000	787.3	Belching/Gas/Bloating		493.9	Asthma	000	786.50	Chest Pain
	000.0	rainorgy (ririda)	000	789.0	Abdominal Pain	000	378.9	Crossed Eyes		786.2	Chronic Cough
000	490	Bronchitis	000	564.0	Constipation	000	389.9	Deafness	000	786.09	Difficulty Breathin
000	780.9	Chills	000	787.91	Diarrhea	000	388.70	Earache	000	786.3	Spitting Blood
000	780.39	Convulsions	000	783.6	Excessive Eating	000	388.60	Ear Discharge	000	786.4	Spitting Phlegm
000	780.4	Dizziness	000	575.9	Gall Bladder Trouble		388.30	Ear Noises			
200	780.2	Fainting	000	455	Hemorrhoids (piles)	000	240.9	<b>Enlarged Thyroid</b>			Particular Supplication
000	780.79	Fatigue	000	782.4	Jaundice	000	460	Frequent Colds		GENITO	-URINARY
000	780.6	Fever	000	794.8	Liver Trouble	000	477	Hay Fever	-		
200	784.0	Headache	000	787.02	Nausea	000	784.49	Hoarseness	000	788.36	Bed Wetting
200	780.52	Loss of Sleep	000	536.9	Stomach Pain	000	478.1	Nasal Obstruction	000	599.7	Blood in Urine
000	783	Loss of Weight	000	783.0	Poor Appetite	000	784.7	Nosebleeds	000	788.4	Frequent Urination
000	799.2	Nervousness	000	536.8	Poor Digestion	000	379.91	Pain in Eyes	000	788.3	Lack of Bladder
םםם	729.2	Neuralgia	000	787.03	Vomiting	000	368.9	Poor Vision			Control
000	780.8	Sweats	000	578.0	Vomiting Blood	000	461.9	Sinusitis	000	590.9	Kidney Infection
000	786.07	Wheezing	000	783.5	Excessive Thirst	000	462	Sore Throat	000	788.1	Painful Urination
	311	Depression	000	536.8	Indigestion	000	463	Tonsillitis	000	601.9	Prostate Trouble
			000	569.3	Rectal Bleeding	000	786.2	Persistent Cough			
						000	787.2	Difficulty Swallowing		And the second	
						000	523.8	Bleeding Gums	11.6 20 1 70		
	MILES	POLICIE POLICE	Para Para	CARRE	NAPOLII AC		CVIN C	R ALLERGIES		EOD W	OMEN ONLY
	, , , , , , , , , , , , , , , , , , ,	ES/JOINTS/BONES			D-VASCULAR				000	7.0000000000000000000000000000000000000	
000	724.5	Backache	000	401.9	High Blood Pressure		680.9	Boils	000	625.3	Cramps or Backaches
000	719.7	Foot Trouble	000	458.9	Low Blood Pressure		924.9	Bruising Easily	000	626.2	Excessive Flow
000	550	Hernia	000	786.51	Pain Over Heart	000		Dryness	000	627.2	Hot Flashes
000	719.1	Pain Between	000	785.9	Poor Circulation	000	691.8	Eczema	000	626.4	Irregular Cycle
	70.1.	Shoulders	000	438	Previous Heart	000		Hives or Allergy	000	634.9	Miscarriage
000	724.6	Painful Tail Bone			Trouble	000		Itching	000	625.3	Painful Periods
000	723.9	Stiff Neck	000		Rapid Heart	000		Sensitive Skin	000	623.5	Vaginal Discharge
000	781.9	Spinal Curvature	000		Slow Heart	000	782.1	Skin Eruptions		611.79	
000	719.0	Swollen Joints	000		Strokes				☐ Yes		Pregnant at this time?
200	781.0	Tremors/Twitching			Swelling Ankles		`		☐ Yes	→ No	Have you had a
300	782	Arm Trouble	000	454	Varicose Veins						mammogram?
									***********		Last Pap Smear Date
				-		-					By Whom
					OPERATIONS A	ND PRO	CEDUR				
DATE				DA	ATE			DATE			
		Vaccinations		A 10	T	ubes in	Ears	10 <u> </u>	Julius 100	Sinus	S
		Tonsillectomy				Appende	ectomy			Hern	ia
MIN	0.518	Gall Bladder				emale (				Thyro	
~		Back Operation	on	-		Rectal S		-		Stor	
	- 37	Other:	JII.	-		Other:	urgery	1		Otho	r:
		Other.				Julei:	91.				
u i ha	ve nev	er had any opera	itions / s	surgerie	S				-		
list an	y accide	ints or falls and da	tes: 🗆 C	ar:	O School:	die .	73	Hecreation:	···		
ال ا	Sports:	h	a1! -1		a scrioor:	77		U Otne	•		7
		bones (fractures)					- 1				
		es? Yes No				-		Haran Landson			The same of the sa
Have y	ou ever	had any spinal tar	s or spir	nal inject	ions? Tyes N	o V	Vere you	ever knocked unc	onscious	? • Yes	s 🗆 No
					The second second		965				
Have	OH AND	had X-rave taken	D Voc	D No.	When?		By Who	nm?			STREET DEST
							by will				
ror wh	iat ailme	ents were these X-	rays mad	16./							
Do you	suffer t	from any condition	other the	an that fo	or which you are no	ow cons	ulting us	7			- The second second
Are yo	u presei	ntly taking any med	dication -	prescrip	otion or over-the-co	ounter?	☐ Yes I	☐ No What drugs	?		GRADINES OF THE
		0 0		1,3				Pyeny Amaga Mil			A STATE OF THE STA
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											prepare reports and forms payments made from the
											red to me are my personal
											nent, any fees for services
								pay all fees involved in or			
		Stelline.	14 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1866	DATE					
author	ize the Do	octor to examine and tr	eat my cor	ndition as o	deemed appropriate thr	ough the u	use of Chi	ropractic Health Care. a	ind I give a	authority fo	or these procedures to be
perform	ed. The a	mount paid to the Docto	or's office fo	or X-rays is	for the examination only	y; the X-ray	y negatives	s will remain the propert	v of the Do	ctor's office	e and will remain on file at
the Doc	tor's office	as long as I am a patie	ent. I am ti	he respons	sible party for payment of	of any treat	tment rece	ived or incurred on this	account. T	his Doctor	provides only chiropractic
care an	d is not re	sponsible for any pre-ex	isting medi	cally diagn	osed conditions or for n	naking any	medical d	lagnosis.			
Patier	nt's/Gua	ardian's Signatur	e: X_	3 35	Refin filesation	SARS	700	legbyr - dri gylli	Date:		
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# Doubrava Family Chiropractic

# 32 Washington Ave.

# Endicott, NY 13760

### **HIPAA Information**

Patients Name			DOB	r :	
May we leave appointme	ent information on (pl	ease circle)			
Home Telephone	Yes	No			
Cell Phone	Yes	No			
May we leave Medical In	formation on (please	Circle)			
Answering Machine Yes No	Yes	No	С	ell Phone	
Office Voicemail Yes No	Yes	No	S	end Through Mail	
Send Through Email No	Yes	No	With	Another Person	Yes
I hereby give permission individuals (Parents, Fam		, or others who			
riame of person	Heldeloi	.511112		Contacts / None in	
				2	<del>Mariana.</del> J
	v				<del></del>
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			X	
I have received and revie	wed the HIPAA state	ment			
Signature of Patient or G	uardian			Date	

### Dr. Cory Doubrava - Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his\her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations or joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of Risks Occurring:** The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular incident, has been estimated at one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other Treatment Options: May include over-the-counter analgesics, prescription medications, injections, and surgery.

**Risks of Remaining Untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the conditions and make future rehabilitation more difficult.

I understand that my doctor will share with me his opinion regarding protential results from chiropractic treatment for my condition and will discuss treatment options with me before I consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

		-				
Printed name	1			Signature		
Consent to T	reat Minor - For use	when Applicab	le			
hereby authorize D	r. Cory Doubrava to administe	er chiropractic care, as d	eemed necessary,			
o my child:		_1 11				
					-	
Printed name						
Signature					Date	