ChiroCare *Express* ~ Pebblebrooke Chiropractic, LLC
Dr. Darci D. Mull ~ Chiropractic Physician
15205 Collier Blvd., Suite 105
Naples, Florida 34119
(239)330-3830

Date: Acct. #:

Name: ______________________________ Your called name: __________________
(Please Print all information clearly)

Date of Birth: ________________ Age: __________

Address: ______________________________ City: ______________________________

State: _____ Zip: __________ Preferred phone #: ______________________________ circle: Home or Cell Phone

Email Address: ______________________________

Receiving our emails is important for YOUR convenience. We will notify you of EXCEPTIONS to our walk-in hours, such as vacation closings. We want you to arrive to an OPEN office. We do NOT send spam or sell our email list.

Your Occupation: ______________________________ Spouse's name: __________________

Emergency Contact: ______________________________ Emergency Contact Phone #: ____________________

Whom may I thank for referring you to my office? ______________________________

Have you ever received Chiropractic care? circle **Yes** or **No** If yes, when?: ______________________________

What brings you to my office (what condition or maintenance/prevention?) ______________________________

____

Date condition began? ________________ How did it happen? (Accident, Injury or Fall) ______________________

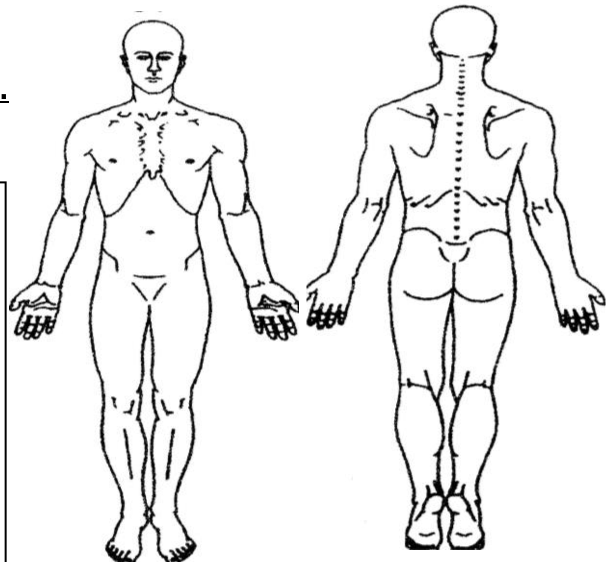
What makes it better? ______________________ What makes it worse? ______________________________

Rate the degree of your pain on a scale of **1 to 10** (1 is low pain – 10 is severe)
Circle one: **1 2 3 4 5 6 7 8 9 10**

Type of Pain: ___Sharp ___Dull ___Throbbing ___Tingling ___Aching
Check all that apply
___Shooting ___Stabbing ___Burning ___Radiating ___Numbness

Check one: ___Pain is Constant (or) ___Pain comes and goes

Please draw the location of your pain on these figures. Use an X or circle to identify the areas.
Also, if you have radiating pain, draw a line with an arrow to the area of radiation.



Check one: Dr. Darci offers both chiropractic adjustments and PNT (Pain Neutralization Technique) for chronic pain.

___ **I want pain relief ONLY. (I'm not interested in prevention)**
Get treated as often as you can. *Everyday, or even twice a day, will get the quickest results for pain relief.*

___ **I want pain relief AND regular preventative adjustments.**
After pain relief, consistent preventative adjustments:

- Keep your pain from returning; improve range of motion.
- Help you play your favorite sports longer & injury-free.
- Make you more resistant to injury from accidents/falls.
- Stop spinal decay: arthritis and bone spurs in the spine.
- Improve posture and prevent the "senior slump."
- Boost your immunity and keep you healthy!

Have you ever suffered from or been diagnosed as having a condition related to:
(please circle Yes or No for each)

Y N Broken Bones	Y N Seizure Disorder	Y N Herniated/Bulging Disc
Y N Circulatory Problems	Y N Hand/Foot Neuropathy	Y N Diabetes
Y N Rheumatoid/Osteo Arthritis	Y N Pacemaker	Y N Women: Pregnant Now?
Y N Colon/Intestines/Digestion	Y N Heart Disease	Y N Cancer/Tumor
Y N Osteoporosis	Y N Stroke or TIA	Y N Allergies
Y N Bruising or Bleeding	Y N Gall Bladder	Y N Concussion/TBI
Y N High/Low Blood Pressure	Y N Kidney/Urinary Bladder	Y N Depression
Y N High Cholesterol	Y N Persistent Cough	Y N Headaches

Please EXPLAIN all "YES" answers that you circled above:____

____

____

List Surgeries:

Location on body & reason: ____ Date: _____________

Location on body & reason: ____ Date: _____________

Location on body & reason: ____ Date: _____________

List Any Accidents, Major Injuries or Falls:

Describe: ____ Date: _____________

Describe: ____ Date: _____________

List Current Medications and the Condition Treated (purpose):

Drug: ______________ Condition: _____________ | Drug: ______________ Condition: _____________

Drug: ______________ Condition: _____________ | Drug: ______________ Condition: _____________

Drug: ______________ Condition: _____________ | Drug: ______________ Condition: _____________

When was your last physical exam? _____________By whom: _____________________________________

What are you expecting from your care?____

Anything else you'd like to tell Dr. Darci? ____

I understand that ChiroCare *Express* is a very specialized chiropractic office, providing only brief spinal adjustments for general health and wellness which may or may not relieve symptoms; therefore, I further understand that Dr. Darci does not treat or diagnose specific conditions other than a misalignment of the body's vertebra. I acknowledge that my visits are NOT covered by any insurance or Medicare and that Dr. Darci does not complete reimbursement forms. A copy of the Informed Consent and Privacy Policy has been provided to me.

______________________________ ____________________________ ____________

Signature Print Name Date

If signing for a minor, print child's name here:_______________________________________

Notice of Our Policy Regarding Prepaid Package Visits

Updated March 6, 2020

Print Patient Name: ____________________________________

For package visits purchased after January 1, 2020:

Expiration

All packages purchased after January 1, 2020 have an expiration as shown on the Fee Summary.
By purchasing a package, you're notified that:

- Once purchased, unused package visits are not refundable for any reason.
- You are responsible for planning your visits prior to the expiration date:
  - We suggest to check the calendar & plan ahead.
  - Keep in mind that your package may expire on a date that we are not open.
  - We do not provide reminders of expiration.
  - There are no extensions to the expiration date under any circumstances.
- You will assume the risk of Dr. Darci's unavailability to provide treatment due to her absence, office waiting times, or for any other reason.
- Package visits are valid only for in-office maintenance care for the purchaser and may not be shared, transferred, or used for any other purpose such as phone consults with Dr. Darci.
- If you prefer, you may use two visits from your package in one day—such as morning & evening.
- Package visits are not a guarantee of treatment: Dr. Darci always has the right to deny treatment.

If these terms are not agreeable, consider our pay-per-visit option for treatment.

For package visits purchased PRIOR TO 2020:

If you have a package with unused visits that you purchased PRIOR TO 2020, you are notified that at some time during 2020, we will likely refund the unused portion of your account balance.

This action will bring your account balance to zero and require you to pay for your visits at the prevailing 2020 fees, if you choose to continue care with Dr. Darci.

We encourage you to utilize your unused visits in your package while you have the opportunity.

I acknowledge receipt of this notice:

Patient Signature _______________________________ Date: _________

Informed Consent

PRINT PATIENT NAME: ____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Dr. Darci provides maintenance care only: You are consenting to a brief maintenance treatment for general health and wellness which may or may not result in relief of your symptoms. You understand that Dr. Darci does not treat or diagnose specific conditions and your visits are not covered by insurance or Medicare. You are consenting to treatment in an open room environment with others nearby.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. Dr. Darci may use that procedure to treat you. She may use her hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles.

Analysis / Examination / Treatment: As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal and/or extremity manipulative therapy (the adjustment), soft tissue technique, palpation & range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, intersegmental traction (roller massage therapy).

Please list any procedures above that you are NOT consenting to (leave blank if you consent to all):

____

The risks inherent in chiropractic adjustment and therapy: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: stiffness, soreness, skin irritation, dizziness, fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, 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. Some patients will feel some stiffness and soreness following the first few days of treatment. Dr. Darci will make every reasonable effort during the initial examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to Dr. Darci's attention, it is your responsibility to inform her and her staff prior to treatment at any time.

The probability of those risks occurring: Mild stiffness and soreness is common after treatment; severe reactions are rare. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options: Other treatment options for your condition may include: full-service chiropractic offices which offer more than maintenance care; self-administered, over-

Informed Consent, continued

the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers; hospitalization; surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

As parent or guardian of this minor child _________________________________, I hereby request and authorize Dr. Darci to perform diagnostic tests and render chiropractic adjustments and other treatment to him/her. As of this date, I have the legal right to select and authorize health care services for this child. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Darci and/or the office manager and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _________________________

____
Print Patient's Name

____
Patient's Signature

____
Signature of Parent or Guardian
(If patient is a minor)

Dated: ___________________________

Darci D. Mull, DC___________________
Doctor's Name

____
Doctor's Signature