



**CONFIDENTIAL PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Employment Type

Student

Address: \_\_\_\_\_

Retired

Full time

Full time

Half time

Name of family Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

What was the date of your last physical? \_\_\_\_\_ Last spinal X-ray? \_\_\_\_\_ Last MRI? \_\_\_\_\_

For Women, are you pregnant?  Yes  No Due date \_\_\_\_\_

**CHIROPRACTIC EXPERIENCE**

Who referred you to this office? \_\_\_\_\_ Had you heard of us before?  Yes  No If yes, how? \_\_\_\_\_

Have you been adjusted by a Chiropractor before?  Yes  No Doctor's name: \_\_\_\_\_

What was the reason for those visits? \_\_\_\_\_ Approximate date of your last visit \_\_\_\_\_

Has any adult in your family seen a Chiropractor? \_\_\_\_\_ Has any child in your family seen a Chiropractor? \_\_\_\_\_

**HEALTH HABITS**

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking
- Alcohol
- Coffee/ Caffeine drinks
- High stress

Packs /day \_\_\_\_\_  
 Drinks/week \_\_\_\_\_  
 Cups/day \_\_\_\_\_  
 Reason \_\_\_\_\_

Medications/ Dosage/ Condition

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Vitamins/ Herbs/ Minerals

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ACCIDENT**

Is condition due to an accident?  Yes  No Date \_\_\_\_\_ Type of accident:  Auto  Work  Home  Other \_\_\_\_\_

Who have you reported this accident to?  Auto Insurance  Employer  Work Comp  Other \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**CURRENT CONDITION**

Primary reason for visit (list one) \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

Did anything contribute to the onset? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Does the pain radiate? \_\_\_\_\_ To where? \_\_\_\_\_

Rate the severity of your pain on a scale from 1 (no pain) to 10 (severe pain) \_\_\_\_\_

Type of Pain: (check all that apply)  Sharp  Dull  Throbbing  Numbness

Aching  Burning  Tingling  Cramps  Stiffness  Swelling  Shooting

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:

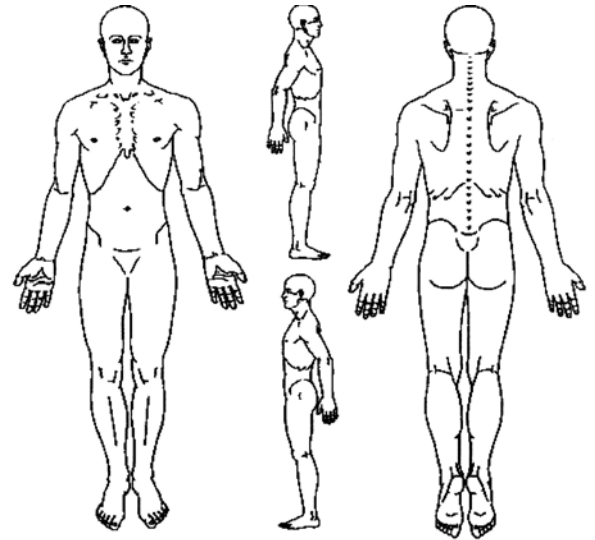
Sitting  Standing  Walking  Bending  Lying Down

What treatment have you received for this condition?  Medication  Surgery  Physical Therapy  Chiropractic  None  Other

Name and address of other medical professional(s) who have treated you for this condition:

\_\_\_\_\_

Mark an "X" on the picture where you continue to have pain.



Secondary reason for visit (list one) \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

Did anything contribute to the onset? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Does the pain radiate? \_\_\_\_\_ To where? \_\_\_\_\_

Rate the severity of your pain on a scale from 1 (no pain) to 10 (severe pain) \_\_\_\_\_

Type of Pain:  Sharp  Dull  Throbbing  Numbness  Aching

Burning  Tingling  Cramps  Stiffness  Swelling  Shooting

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:

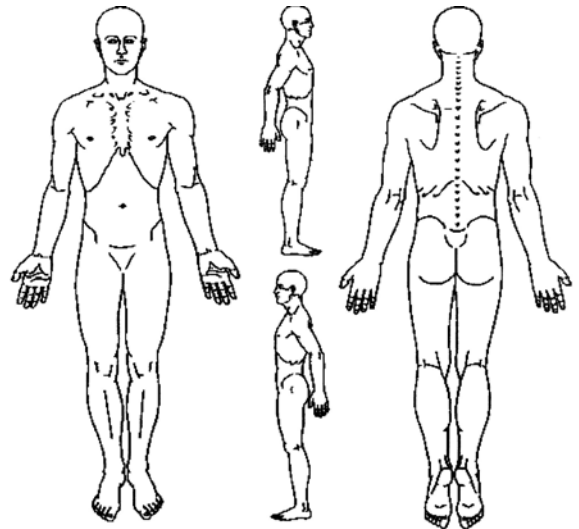
Sitting  Standing  Walking  Bending  Lying Down

What treatment have you received for this condition?  Medication  Surgery  Physical Therapy  Chiropractic  None  Other

Name and address of other medical professional(s) who have treated you for this condition:

\_\_\_\_\_

Mark an "X" on the picture where you continue to have pain.



**HEALTH HISTORY**

<u>Condition</u>	<u>Description</u>	<u>Date</u>
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries/hospitalizations	_____	_____
	_____	_____

**Please check any symptoms or diseases below that you are experiencing or have experienced in the past.**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Upset stomach           | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Pain between shoulders  |
| <input type="checkbox"/> Sinus problems          | <input type="checkbox"/> Digestive problems      | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Numbness in extremities |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Bed wetting             | <input type="checkbox"/> Shingles                | <input type="checkbox"/> Pain in extremities     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Ear infections          | <input type="checkbox"/> Kidney problems         | <input type="checkbox"/> Back stiffness/pain     |
| <input type="checkbox"/> Sleeping problems       | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Frequent neck pain      |
| <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Dizziness               |
| <input type="checkbox"/> Alcohol/Drug dependency | <input type="checkbox"/> Difficulty breathing    | <input type="checkbox"/> Thyroid problems        | <input type="checkbox"/> TMJ/Jaw problems        |
| <input type="checkbox"/> PMS                     | <input type="checkbox"/> Heartburn/Acid reflux   | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Loss of balance         |
| <input type="checkbox"/> Menopause               | <input type="checkbox"/> Recurring infection     | <input type="checkbox"/> Depression              | Other _____                                      |
| <input type="checkbox"/> Heart Attack/Stroke     | <input type="checkbox"/> Sudden weight loss      | <input type="checkbox"/> Infertility/Miscarriage | Other _____                                      |

**Please explain each symptom or disease in the space provided below:**

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**TERMS OF PAYMENT**

Payment is expected at the time of treatment. A missed appointment or cancellation without a 24 hour notice may result in a charge of **\$25.00**.

Name of person financially responsible: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Company #1:** \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_  
Policy Holder:  Male  Female Marital Status:  Single  Married  Divorced  
Your relationship to insured: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Insurance Company #2:** \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_  
Policy Holder:  Male  Female Marital Status:  Single  Married  Divorced  
Your relationship to insured: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that a missed appointment or cancellation without notice may result in a charge of **\$25.00**.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

**RELEASE AND ASSIGNMENT**

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. For this reason, the terms used are:

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction or vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

A.R.T. Active Release Techniques is a process of identifying and removing soft tissue abnormalities utilizing specific contacts and ranges of motion.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation and soft tissue neuromuscular dysfunctions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatments for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. We do not offer advice regarding treatment by others.

Our GOAL is to eliminate dysfunction within your neuromuscular and biomechanical systems. Our methods include specific adjusting to correct vertebral subluxations and A.R.T.

I, \_\_\_\_\_ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction.

I therefore accept chiropractic care on this basis.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA Notice of Privacy Practices

This summary discloses how health information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY.

Adair Chiropractic P.L.C. uses health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

Adair Chiropractic P.L.C. will not disclose your information to others unless you tell us to do so with written consent, or unless the law authorizes or requires us to do so.

Adair Chiropractic P.L.C. may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Adair Chiropractic P.L.C. may disclose your information for health and safety of governmental functions in order to comply with workers compensation laws and regulations, and a right to request restriction, report and retain a copy of your health record, request communication or your information by alternative means at alternative locations, revoke your authorization and request an account of your health records.

You may complain to the Department of Health and Human Services if you believe your rights have been violated. You will not be retaliated against for filing a complaint.

Adair Chiropractic P.L.C. must retain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or concerns please contact our HIPPA Compliance Officer in person or by phone at 319-665-2323.

Printed Name(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_