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CONFIDENTIAL PATIENT INFORMATION

Patient Title: □ Mr. □ Mrs. □ Ms. □ Miss □Dr. □Prof. □ Rev. Today's Date: _____

Full Name: _____ Preferred name: _____

Age: _____ Sex: _____ Marital Status: _____ Birth Date: _____

Address: _____City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Mobile Phone: _____

Home E-mail: _____ Work E-mail: _____

Which email address would you like us to communicate with you? (*check one*) □ Home □ Work

Contact Method (*check one)* □ Primary Phone □ Secondary Phone □ Mobile Phone □ Home Email □ Work Email

Can we send you a text reminder for appointments? □Yes □No

Social Security Number: _____

Employer: _____ Student: □ Full time □ Part time

Race: □White □Black □Hispanic □Asian □Other: _____

Multiracial: □Yes □No □Unknown/Prefer not to answer

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Choose not to specify

Preferred Language: □English □Spanish □Choose not to specify □Other: _____

VERIFICATION QUESTION (choose only one question, and provide the answer to that question, to be used for Patient Portal):

□What is the name of your favorite pet? □In what city were you born? □What high school did you attend?

□What is your favorite movie? □What is your mother's maiden name? □On what street did you grow up?

□What was the make of your first car? □When is your anniversary?

Verification answer to the chosen question: _____

CHIROPRACTIC EXPERIENCE

Who recommended our office to you? _____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: _____

HEALTH HABITS

Exercise	Work Activity	Habits	
□ None	□ Sitting	□ Smoking	Packs /day_____
□ Moderate	□ Standing	□ Alcohol	Drinks/week_____
□ Daily	□ Light Labor	□ Coffee/ Caffeine drinks	Cups/day_____
□ Heavy	□ Heavy Labor	□ High stress	Reason_____

What was the date of your last physical? _____Last spinal X-ray? _____ Last MRI? _____

For Women, are you pregnant? □ Yes □ No Due date_____

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker

If yes, how often do you smoke? □ Current every day smoker □ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

□0 □1 □2 □3 □4 □5 □ 6 □7 □8 □9 □10

No interest *Very interested*

Current Medications, including frequency and dosage. If there are no current medications, check here: □

1._____ 2._____3._____

4. _____ 5._____6._____

Allergies: List any allergies you have to medications. If no allergies are known, check here: □

1._____ 2. _____ 3. _____

CURRENT CONDITION

Primary reason for visit (*list one*) _____

When did your symptoms begin? _____

Did anything contribute to the onset? _____

What makes it better? _____

What makes it worse? _____

Does the pain radiate? _____To where? _____

Rate the severity of your pain on a scale from 0 to 10; with 0 being no pain and 10 being extreme pain: _____

Type of Pain: (*check all that apply*)

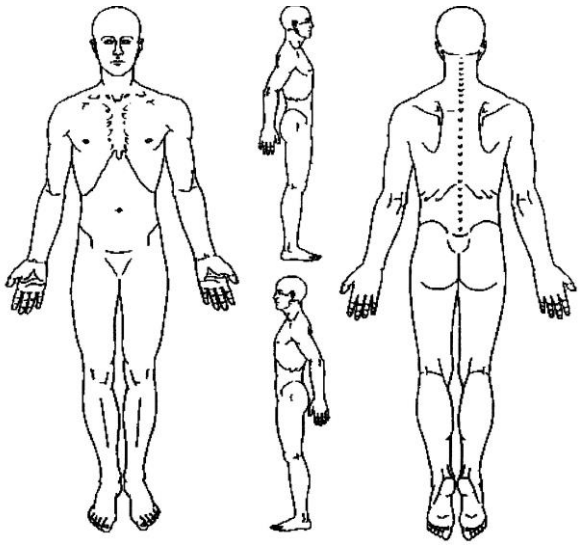
□ Dull □ Sharp □Throbbing □Burning □Deep □ Aching
□Tingling □Stabbing □Cramping □Numbness □Radiating □Stiffness

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

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



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 of other medical professional(s) who have treated you for this condition: _____

List any secondary complaints here: _____

HEALTH HISTORY

Condition	Description	Date
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.

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

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

To be performed by clinic staff:

Height: _____inches Weight: _____ pounds Blood Pressure: _____/_____

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: _____