WELCOME BACK TO ADIO CHIROPRACTIC

Patient Name:_____ Email: _____

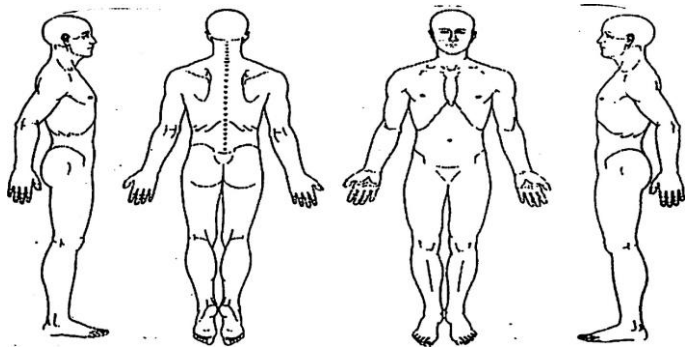
Has your address or phone changed since your last visit?_____
Do you have new insurance? _____

1. When did your symptoms start?_____ Describe your symptoms and how they began:

2. How often do you experience your symptoms?
   - ○ Constantly
   - ○ Daily (l or more episodes a day)
   - ○ Weekly (l or more episodes a week)
   - ○ Rarely

3. How would you best describe your symptoms?
   - ○ Sharp
   - ○ Shooting
   - ○ Dull Ache
   - ○ Burning
   - ○ Tingling
   - ○ Numb
   - ○ Soreness
   - ○ Tightness
   - ○ Other:_____

Indicate on the figure where your pain or symptoms are:



4. Are your symptoms changing? (circle one) Getting Better, Getting Worse, Staying the Same

None *Unbearable*

5. How bad are your symptoms at their: Best: 0 1 2 3 4 5 6 7 8 9 10

   Worst: 0 1 2 3 4 5 6 7 8 9 10

6. How do your symptoms affect your ability to perform daily activities? (circle one)

   ○ No Effect ○Mild, Does Not Limit Activity ○ Moderate, Limits Activity ○ Severe with Minimal Activity ○Severe, No Activity Possible

7. At its worst what can you not do? _____

8. What activities make your symptoms better? _____

9. Have you had the exact symptoms before: No Yes ○ If exact symptoms in past did you receive treatment: No Yes

10. Other Doctors or treatment for this condition: _____

11. What do you hope to achieve from your visit at this office? (circle one)
    a. Explanation of problem b. Reduce symptoms c. Resume normal activity d. Correct problem and prevent recurrences

12. Has there been any changes in your health history? (New injury, surgery, medications, etc.)

Other Comments: _____

Patient Signature:_____ Date:_____
Parent if under 18

FEMALES ONLY

Is it possible that you are pregnant? Yes □ No □ If Yes, what is your due date: _____

Terms of Acceptance

In order to provide for the most effective healing environment, and the strongest possible doctor-patient relationship, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

1. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
2. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health advice regarding treatment prescribed by others.
3. Your compliance with care plans, home, and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
4. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I _____ have read and fully understand the above statements.

(print name, Parent if under 18)

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, Parent if under 18) (Date)

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing that you restrict how my private information is used to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____ _____

Signature, Parent if under 18 Date

Payment and Insurance

I do hereby authorize ADIO Chiropractic to administer such care that is necessary for my particular case. I further agree to pay for services rendered as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between myself and an insurance carrier and that I may be personally responsible for payment of any and all services rendered. 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 authorize ADIO Chiropractic to share such personal information as needed to submit insurance claims on my behalf (If I have insurance) and I authorize payment from my insurance carrier to ADIO Chiropractic for services rendered.

_____ _____

Signature, Parent if under 18 Date