ADULT INTAKE PACKET

Patient Demographics

Legal Name:_____ Date of Birth:_____-_____-_____ Age:_____ Male / Female

Home Phone:_____ Cell Phone:_____ E-Mail:_____

Address:_____ City:_____ State:_____ Zip:_____

Are you seasonal: □ Yes □ No Non-Florida Address: _____

If seasonal what dates you are in Florida: _____ Height:_____ Weight:_____

Marital Status: □ Single □ Married □ Other Do you have Insurance: □ Yes □ No Insurance Company Name: _____

Are you employed? □ Yes □ No □ Retired Employer Name: _____

Do you have kids? □Yes □ No If yes, what are their ages? _____

Females only, is it possible you are pregnant? □ Yes □ No If yes, what is your due date? _____

Emergency Contact Name and Phone Number: _____

Who can we thank for referring you to our office? _____

Health History

Please tell us the condition(s) you are seeking chiropractic care for: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of 0 to 10, with 0 being no pain, rate your above conditions by circling the number.

Primary	0	1	2	3	4	5	6	7	8	9	10
Secondary	0	1	2	3	4	5	6	7	8	9	10
Third	0	1	2	3	4	5	6	7	8	9	10
Fourth	0	1	2	3	4	5	6	7	8	9	10

About when did the symptom(s) begin? _____ Have you had the symptom(s) before? □ Yes □ No

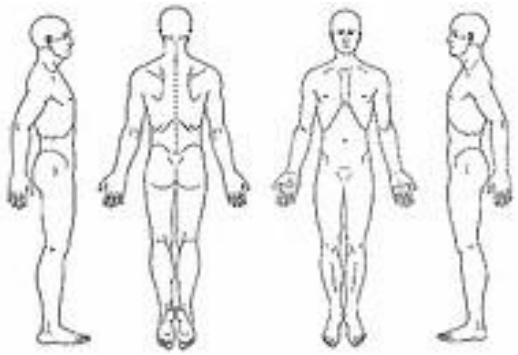
When is the symptom(s) at worst? □ First thing in the morning □ Mid-day □ Afternoon □ Evening □ Same throughout the day

Is your symptom(s): □ Constant □ On and off throughout the day □ On and off throughout the week

What activities make your symptom(s) worse? _____

What, if anything, relives your symptom(s)? _____

Place an X on the diagram below where you are experiencing any pain, numbness, tingling or other symptoms.



Is this condition(s) due to an injury? □ Yes □ No How did the injury happen? _____

Have you tried another form of treatment? □ Yes □ No If yes, what? _____

How long ago did try it? _____ Where the results favorable? □ Yes □ No

Have you received chiropractic care in the past? □ Yes □ No If yes, when was your last adjustment? _____

What was the name of your previous chiropractor or chiropractic office? _____

At any point in your life have you experienced one or more of the following?

□ Asthma □ Broken Bone □ Cancer □ Cerebrovascular Disease □ Diabetes □ Disability

□ Dislocation □ Fainting/Seizures □ Fracture □ Heart Attack □ Osteo-Arthritis □ Osteoporosis

□ Rheumatoid Arthritis □ Tumor □ Other: _____

Please list all current medications:_____

_____

Please list any past surgeries: _____

_____

Social History

Do you smoke? □ Yes □ No If yes, how often? □ Daily □ Weekly □ Occasionally

How often do you consume alcoholic beverages? □ Daily □ Weekly □ Occasionally □ Never

Do you use recreational drugs? □ Yes □ No If yes, how often? □ Daily □ Weekly □ Occasionally

Physical Activity Level

How often do you exercise? □ None □ 1-3 times a week □ 4-7 times a week

What kind of exercise do you do? □ Bicycling □ Cross Fit □ Gym □ Pilates

□ Recreational Sports □ Running □ Walking □ Yoga □ Other:_____

Do you… □ Sit more than 4 hours per day □ Drive more than 2 hours per day

I 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 an insurance carrier and myself 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.

_____ _____

Patient Signature Date

Activities of Daily Living

How is your current condition affecting your abilities to perform the activities below?

Bathing	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Bending	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Computer Work	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Concentrating	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Dressing	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Driving	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Grooming	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Household Chores	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Lifting Objects	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Sexual Activity	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Preparing Meals	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Reading	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Running	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Sitting	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Sleeping	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Standing	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Transferring from, to Sitting/Standing/Lying Down	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform
Walking	□ No Effect	□ Painful, but can preform	□ Painful, limits performance	□ Unable to preform

_____ _____

Name Date

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference.

EXAMPLE:

headache neck low back

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

1. What is your pain RIGHT NOW?

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

2. What is your TYPICAL or AVERAGE pain?

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

3. What is your pain level AT ITS BEST?

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

4. What is your pain level AT ITS WORST?

No Pain 0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10 Worst Possible Pain

5. What percentage of your awake hours is your pain at its worst? _____%

_____ _____

Patient Name Date

FOR OFFICE USE PLEASE DO NOT WRITE BELOW THIS LINE **FOR OFFICE USE PLEASE DO NOT WRITE BELOW THIS LINE**

#1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 =_____

< 50 Low Intensity, > 50 High Intensity

Notice of Privacy Practices

Our office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your personal health information. In addition we must provide you with written notice concerning your rights to gain access to your personal health information and the potential circumstances that our office is permitted to, legally, disclose information about you to a third party without your authorization. If you wish to keep a copy of this form for your records, please inform the front desk.

A. Your personal health information can be used without your authorization for -

• Treatment – to conduct, plan, and direct your treatment and follow-up with any other health care providers who may be involved with your case

• Payment – to collect payment from insurance companies or other collateral sources

• Emergencies – in the event of an emergency we may contact a family member

• Inadvertent Disclosures – due to the nature of our semi-open adjusting areas individuals may overhear conversation. In the event you need to discuss a confidential matter with the doctor we can schedule a consultation in a private room

• Change of Ownership – in the event the practice is sold, the new owner will have access to your personal health information

• Public Interest – when your information is requested for by statute, regulation, or court order

B. You have the right to:

• Receive ONE copy of your records at no charge when adequate notice is given (2 business days

• Receive a paper copy of the Detailed Privacy Notice

• Requesting mailings be sent to an address different than that of your residence

• An account of who your personal health information has been disclosed to per the above mentioned section A

• Request restrictions to whom we disclose your personal health information to per the above section A, though ADIO Chiropractic is not required to comply

I, _____ have read and fully understand the above statements.

_____ _____

Signature Date