Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About this Patient

First Name ______________________

Last Name ______________________

Cell Phone ______________________

Birth Date ______________________

Marital Status
- ◯ Single
- ◯ Married
- ◯ WIDOW
- ◯ Other

Gender ______________________

Email ______________________

Height / Weight ______________________

Street Address ______________________

City ______________________

State/Province ______________________

Zip Code ______________________

HOW DID YOU HEAR ABOUT US?
- ☐ GOOGLE
- ☐ WEBSITE
- ☐ Primary Care Dr
- ☐ Referred by Patient

Referred By/ Patient Name ______________________

Primary Doctor Name & Address ______________________

Primary Dr Phone # ______________________

Emergency Contact

Emergency Contact Last Name ______________________

Emergency Contact First Name ______________________

Emergency Phone Number ______________________

Emergency Contact Relationship ______________________

Employer Information

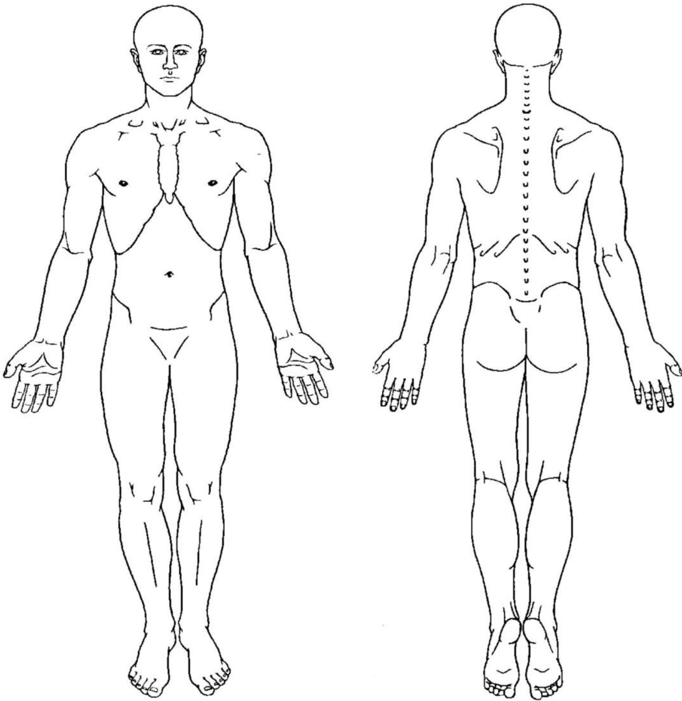
Employer ______________________

Type of Work ______________________

Employer Status ______________________

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point with an X



Is the purpose of this appointment related to:

- ◯ Job
- ◯ Sports
- ◯ Auto
- ◯ Fall
- ◯ Chronic Discomfort
- ◯ Home Injury
- ◯ Other

If job related, have you made a report of your accident to your employer?

- ☐ Yes
- ☐ No

Initial Consultation Form

Primary Complaint (s):

____

When did your condition begin?

____

Does this condition interfere with

- ☐ Work
- ☐ Sleep
- ☐ Daily Routine
- ☐ Other activities

Has this condition

- ◯ Gotten worse
- ◯ Stayed Constant
- ◯ Comes and goes

Has this condition occurred before?

- ◯ Yes
- ◯ No

Have you seen other doctors for this condition?

- ◯ No
- ◯ Yes

Type of Treatment

____

Overall intensity of complaint (choose one)

- ◯ Minimal (An annoyance but has no effect on activity)
- ◯ Slight (Tolerable with some impairment to activity)
- ◯ Moderate (Tolerable with marked impairment of activity)
- ◯ Severe (Intolerable and cannot perform any activities)

Overall frequency of complaint (choose one)

- ◯ Constant - 100% of the time
- ◯ Frequent - 75%
- ◯ Intermittent - 50%
- ◯ Occasional - 25%

Is this problem affecting any other area of your body? If yes, please explain:

____

Does your symptoms increase while performing your normal work duties?

- ◯ Yes
- ◯ No

Experience with Chiropractic

Have you been adjusted by a chiropractor before?

◯ Yes ◯ No

Approximate date of last visit?

____

Health Habits & Conditions

MEDICATIONS/ SUPPLEMENTS YOU TAKE (Bring list if needed) ______________________________

Medications I Now Take:

- ☐ None
- ☐ Pain Killers (including Aspirins)
- ☐ Muscle Relaxers
- ☐ Blood Pressure Medicine
- ☐ Insulin
- ☐ Stimulants
- ☐ Blood Thinners
- ☐ Steroids
- ☐ Nerve pills
- ☐ Others-see list

Drug Allergies

____

Do you exercise regularly?

◯ Daily ◯ Moderately ◯ No

Health Conditions:

- ☐ Severe or Frequent Headaches
- ☐ Sinus Problems
- ☐ Dizziness
- ☐ Cancer
- ☐ Loss of Sleep
- ☐ Hepatitis
- ☐ Pain Between the Shoulders
- ☐ Frequent Neck Pain
- ☐ Numbness in Arms/Legs/Hands
- ☐ Lower Back Problems
- ☐ Digestive Problems
- ☐ Ulcers/Colitis
- ☐ Heart Attack/Stroke
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Congenital Heart Defect
- ☐ Heart Surgery/Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Arthritis
- ☐ Alcohol/Drug Abuse
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Shingles
- ☐ Chemotherapy
- ☐ Anemia
- ☐ Pregnant
- ☐ Pace Maker
- ☐ Not Applicable

Family Health History

- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ CANCER
- ☐ KIDNEY PROBLEMS
- ☐ THYROID PROBLEMS
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ NONE
- ☐ OTHER

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered. Signature below states that you understand & agree to these terms. Please initial once in the office. ______________

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort

☐ Yes

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

☐ Yes

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

☐ Yes

Authorization to Release Medical Information

By signing below you are authorizing Adamec Chiropractic permission to release any or all information concerning your examination, diagnosis, treatment, or diagnostic results to your Primary Care Physician/and or referring specialist.

Signature

Date Signed ______________________________

Printed Name ______________________________

Email ______________________________

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.

- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards & text messages are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment with our chiropractic assistants. We would prefer the make up appointment to be within the same week.
- In the instance of a no show without notice by phone we reserve the right to charge you a $40.00 fee.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

Signature below states that you understand & agree to these terms.

Insurance:

We will verify all insurances and your benefits per your agreement with your carrier. After verification the Doctor will give his recommendations and an appropriate plan will be designed for each individual. Please let the front-desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Office Fee Schedule and Financial Policy

Consultation	**No Charge**
Initial Exam/Computer Scans	**$100-$200**
Dynamic Re-Exam/Computer Scans	**$70-$150**
MLS Laser Treatments (Single region)	**$360-$720**
Adjustments/Therapies	**$50-$100**
Wellness Adjustment Plans	**$110-$550**

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well being and we will do our best to help you.

Signature **Date Signed** ______________________

Printed Name ______________________ **Email** ______________________