Patient Demographics

First Name:_____ M.I.: _____ Last Name: _____

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

DOB: _____Phone:_____ Email:_____

Emergency Contact Name:_____ Phone #:_____

Primary Care Physician:_____

Insurance:_____ ID#:_____ Group #:_____

Primary Cardholder Relationship: □ Self □ Spouse □ Parent □ Other:_____

Primary Cardholder's Name: _____DOB: _____

Occupation:_____ Employer:_____ City: _____

Would your employer be interested in on-site Health and Wellness classes? □ YES □ NO

If yes, who would we speak to about setting up an events?_____

Marital Status:_____ Spouse's Name:_____

Do you have children?_____ Ages:_____Have your children been seen by a chiropractor before? □ YES □ NO

How did you hear about Abundant Health Chiropractic?

□ Existing Patient: _____ □ Internet:_____

□ Ad (please specify):_____ □ Radio (station):_____

□ Community Event:_____ □ Insurance Company: _____

□ Walk In/Drive-By □Other: _____

Patient Health History

Do you consume alcohol? □ Yes □ No How many drinks per day?_____ How often per week?_____

Do you smoke? □ Yes □ No _____ pk/day How many years have you smoked?_____

Do you exercise? □Yes □ No How often?_____x/wk Intensity of exercise: _____

Allergies:_____

Are You Pregnant? □ Yes □ No Date of Last Menstrual Period:_____

Please list surgeries and year:_____

List any recent accidents or falls and date:_____

Please list the medications that you are currently taking?_____

Have you ever received Chiropractic Care in the past? □ Yes □ No Last Visit Date?_____ X-Rays? □ Yes □ No

Patient Health History Cont.

What is your primary complaint?_____

How long have you been experiencing this problem and symptoms?_____ □ days □ weeks □ months □ years

On a scale of 1 to 10, how severe are the symptoms at their worst? 1 2 3 4 5 6 7 8 9 10

What % of your awake time do you experience the symptoms? 0 10 20 30 40 50 60 70 80 90 100

What time of day are the symptoms the most acute? □ Morning □ Afternoon □ Evening □ Overnight

What makes the symptoms better?_____

What makes the symptoms worse?_____

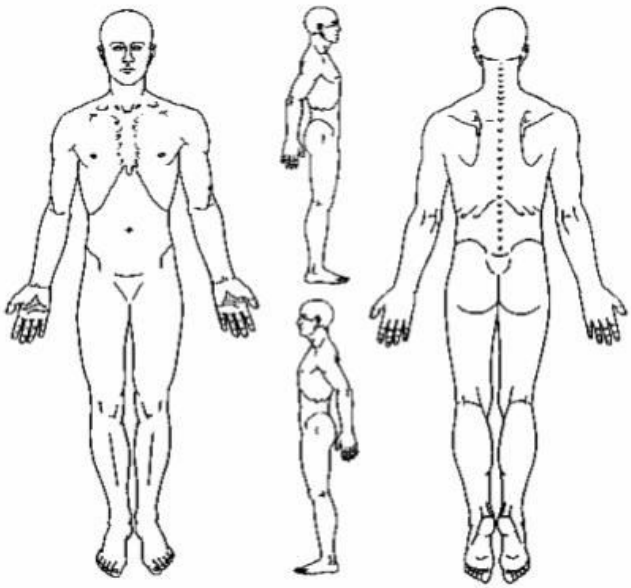
For this problem, what treatments have you sought? □ None □ Hospitalized □ Another Chiropractor

□ Primary Physician □ Physical Therapy □ Other:_____

Please indicate your symptoms with a C for CURRENT symptoms and a P for PAST symptoms.

_____ Arthritis
_____ Neck Pain
_____ Low Back Pain
_____ Upper/Mid Back Pain
_____ Shoulder Pain
_____ Hip Pain
_____ Foot / Ankle Pain
_____ Knee Pain
_____ Numbness /Tingling
_____ Tired Shoulders
_____ Swollen/Painful Joints
_____ TMJ Pain
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Heart Arrhythmias
_____ High Cholesterol
_____ Heart Attack
_____ Heart Disease
_____ Excessive Bleeding
_____ Allergies/Sinuses
_____ Trouble Sleeping
_____ Headaches
_____ Migraines
_____ Trouble Concentrating
_____ Dizziness
_____ Fainting
_____ Tremors
_____ Concussion
_____ Stroke
_____ Epilepsy
_____ Cancer
_____ Tumors
_____ Congenital Disease
_____ Learning Disability
_____ ADD/ADHD
_____ Autism

On the diagram below, label ALL areas you are experiencing symptoms using the appropriate letter from the symptoms listed:
A=Aching **C**=Cramping **R**=Throbbing Pain **N**=Numbness **O**=Other
B=Burning **D**=Dull Pain **S**=Stiffness **T**=Tingling **SH**=Sharp



_____ Ear Infections
_____ Bed Wetting
_____ Asthma
_____ Diabetes
_____ Loss of Balance
_____ Coughing Blood
_____ Pain with Cough/Sneeze
_____ Chest Pain
_____ Gallbladder
_____ Kidney Problems
_____ Ulcers
_____ Heartburn
_____ Diarrhea/Constipation
_____Colon Trouble

_____ Prostate Problems
_____ Menstrual Problems
_____ PMS
_____ Menopausal Problems
_____ Thyroid Problems
_____ Eating Disorder
_____ Mood Changes
_____ Depressed
_____ Alcoholism
_____ Drug Addiction
_____ HIV Positive
_____ Broken Bones
List:_____
_____

TERMS OF ACCEPTANCE AND CONSENT FOR CARE:

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in their body. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, massage therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxations. This is the misalignment of one spinal bone or multiple bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Again, our focus is to correct the cause, not the symptom.

Vertebral subluxations come on from physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat your subluxations and the degenerative processes that are involved the faster and more completely your body will heal. It may be necessary to examine an individual each time a new injury occurs and often x rays are necessary to maintain the utmost safety when dealing with your body. The risks of chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I have read and I accept the terms above and understand them fully. I hereby give consent to the ABUNDANT HEALTH CHIROPRACTIC to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x rays or any treatment if I so choose.

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

_____ _____

Signature Date

FOR MINORS:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

_____ _____

Signature Date

HIPPA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Abundant Health Chiropractic, we may use or disclose personal and health related information about you in the following ways:

• Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

• Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

• Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about a alternative to your present care, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

• If we are providing healthcare to you based on the orders of another healthcare provider.

• If we provide healthcare services to you in an emergency.

• If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.

• If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

• If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences. You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files. Information that we use or disclose based on this privacy notice may be subject to re disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Adam Meade If you would like further information about our privacy policies and practices please contact: Dr. Adam Meade This notice is effective as of January 1st, 2010. This notice, and an alterations or amendments made herein will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Signature Print Date