WELCOME

1. Please complete & return this comprehensive health form no later than 2 weeks prior to your Initial Consultation. This will give you an opportunity to think through & remember your past medical history, your current medical concerns and reasons for seeking my help. This also gives me time to put together a comprehensive plan for you. Please type in the answers, save the PDF, and email it back to abelchiro.team@gmail.com.

2. Your initial consultation is to discuss your health concerns and overall health picture. This will be followed by a physical examination including vital signs, manual muscle testing, and diagnostic chiropractic procedures to determine if chiropractic care is appropriate for your condition.

3. Any additional procedures such as laboratory and x-ray tests, will be recommended and completed outside of the office, if necessary.

4. Proceeding your initial consultation, the doctor will explain your findings from the initial examination and whether or not you are a good candidate for care. It is at this time your recommended treatment plan will be explained and the first adjustment will be given.

5. Treatments will begin and continue as scheduled until your condition has been fully corrected, or until maximum medical improvement has been obtained.

Please complete the following questionnaire before arriving to your appointment. You may fill this form out digitally or print it and bring it with you. If you'd like to fill it out digitally, type in your answers, save the PDF and email it to abelchiro.team@gmail.com

CONTACT INFORMATION

Today's Date: ______________________________

Legal Name: ____

Preferred Name: ____

Date of Birth: ______________________________ Age: _________ Sex: M F Other

Check One: Married Single Widowed Divorced Separated # of Children: ____

Address: ____

Street City State Zip

Home Phone: ________________ Cell Phone: ________________ Office Phone: ________________

Preferred Method of Contact: Home Cell Office Call Text Email

Email Address: ____

May we contact you via email regarding your care? Y N

Employer: ______________________________ Type of Work: _________________________

Emergency Contact: _________________________ Phone Number: _________________________

Who Referred You? _________________________ Can we thank them for the referral? Y N

How did you hear about us? ____

PERSONAL HISTORY

Chiropractic care in the past? Y N Where? ______________ When? ____________

Reason for coming in today: ____

____

When did this condition begin? ____

Have you experienced this condition in the past? Please explain: ________________

____

Please list other doctors you have seen for this condition and the approximate date you were seen:

____

Have you been treated for any health condition in the past year? Y N If yes, explain:

____

Major illnesses: ____

Accidents/falls: ____

Hospitalizations: ____

Surgeries: ____

Current Medications: ____

Current Nutritional Supplements: ____

Exercise: None 1-2 Times a Week 3-4 Times a Week 5-7 Times a Week

Type of exercise and duration: ____

Habits: Smoker: ________ packs a day for ________ years Former Smoker

Alcohol consumption per week: ____________ Caffeine consumption per day: ____________

Water consumption per day: ____________ Soda consumption per day: ____________

Date of last physical: ____

Below is a list of conditions related to your overall health picture. Please answer carefully as these conditions contribute to your overall diagnosis, treatment plan, and whether or not this care is appropriate for your condition.

Check any of the following diseases you have, or have had in the past:

- Appendicitis
- Scarlet Fever
- Diphtheria
- Typhoid Fever
- Pneumonia
- Rheumatic Fever
- Polio
- Malaria
- Tuberculosis
- Whooping Cough
- Anemia
- Measles
- Mumps
- Small Pox
- Chicken Pox
- Diabetes
- Cancer
- Heart Disease
- Goiter
- Influenza
- Pleurisy
- Alcoholism
- Venereal Infection
- Arthritis
- Epilepsy
- Mental Disorder
- Lumbago
- Eczema

Check any of the following you have or have had in the past 6 months:

Musculo-Skeletal:

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/ Clicking Jaw

Nervous System:

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/ Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

General:

- Allergies
- Loss of Sleep
- Fever
- Headaches

Gastro-Intestinal:

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Troubles
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stools
- Colitis

Genito/Urinary:

- Bladder Troubles
- Painful/Excessive Urination
- Discolored Urine

C-V-R:

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems
- Varicose Veins
- Ankle Swelling

EENT:

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulties
- Stuffed Nose

Male/Female:

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/ Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes

Females:

Date of LMP ______

Average Length of Cycle ____________

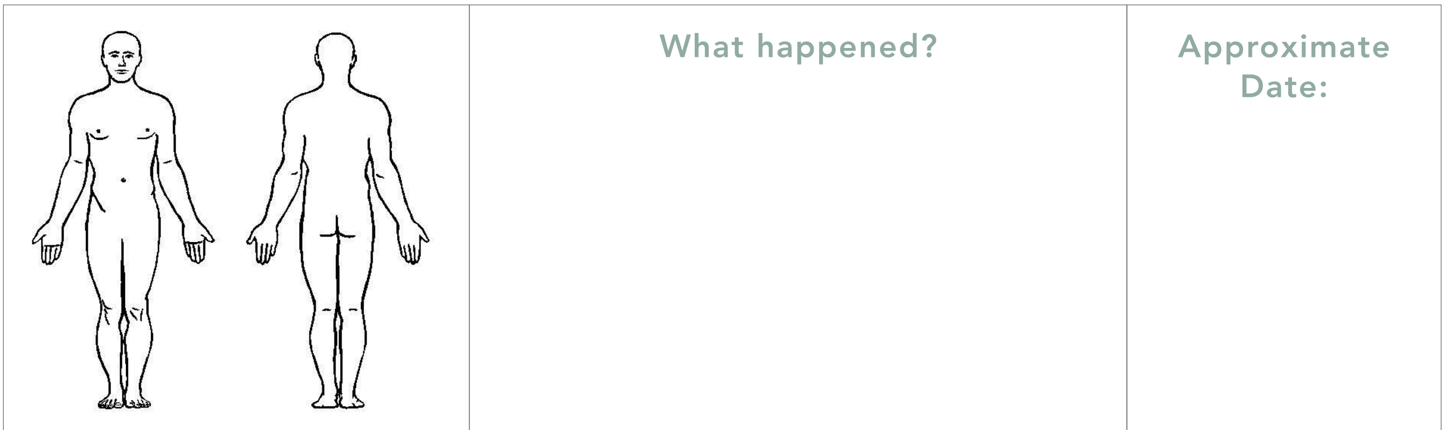
Are you pregnant?

Y N Maybe

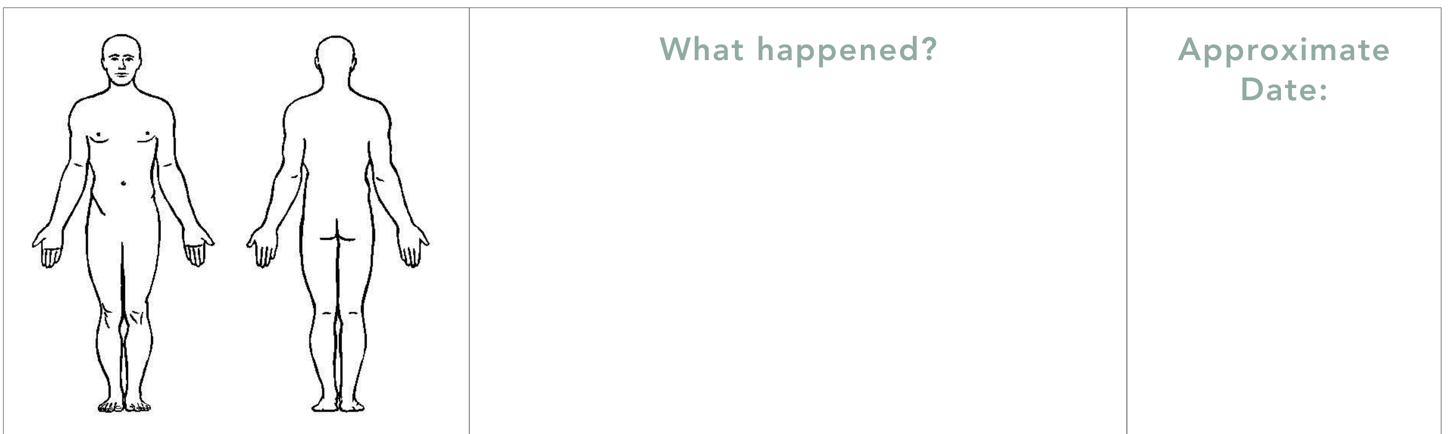
Please mark all areas you have experienced trauma on the figures below using an X, then write the approximate date of the surgery/injury and how the surgery/injury occurred.

Examples: surgeries, sprains, broken bones, concussions, cuts, burns, severe bruises, tattoos, piercings, etc.

	What happened?	Approximate Date:



	What happened?	Approximate Date:



	What happened?	Approximate Date:

TERMS & CONDITIONS

INSURANCE

Abel Chiropractic is an out-of-network provider and do not file insurance. We will provide documentation for you to submit to your health insurance provider. It is best to contact your insurance company to find out what their process is for claim submission and reimbursement. This office does not currently file Medicare or Medicaid paperwork.

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered 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.

Initial: ______

PERMISSION TO TREAT

I hereby give permission to the doctor to administer treatment and perform such general procedures, as he/she may deem necessary in the diagnosis and/or treatment of my condition. I understand fees are payable when services are received, should any legal action be necessary in order to collect fee, all costs associated with the condition and attorney fees shall be payable by the patient.

Initial: ______

ABEL CHIROPRACTIC'S CANCELLATION, LATE, & NO-SHOW POLICY

At Abel Chiropractic, we emphasize high quality chiropractic care and health services with appointments reserved specifically for you. Due to our dedication to your health care, we often have a waiting list for appointment times. If you cancel on short notice, do not show up, or show up very late- it is a lost opportunity for another patient.

We understand unanticipated events happen occasionally in everyone's life and we will take that into consideration, however in our desire to be fair to all patients and maintain a viable practice, the following policies are honored.

Thank you for allowing us to be a part of your health care team! We appreciate your understanding and support.

Cancellations

We ask that you please notify the office with a minimum of 4 hours in advance of your scheduled appointment if you need to change or reschedule. This ensures we best assist those patients who are waiting for care. To reschedule or change your appointment, please call (319) 389-5885. If you do not reach someone from the office, you may leave a detailed message on the answering machine.

If you are unable to give us the full advance notice for appointments, **you will be charged half of the scheduled appointment price. Due before your next appointment.***

Initial: ______

Late Arrivals

If you are running late, please call our office to reschedule. Your appointment will likely be shortened to accommodate those whose appointments follow yours. On occasion, we may be able to work-in late arrivals; however, this is at the discretion of our staff. Regardless of the length of the treatment given, **you will be responsible for the "full" appointment.** If you arrive more than 5 minutes late, we may ask you to reschedule. If this occurs, it will be **considered a Missed Appointment.**

Initial: ______

No Show/Missed Appointments

Anyone who either forgets or consciously forgoes their appointment for whatever reason will be considered a "No-Show" and **will be charged the full amount of their missed appointment.***

Three or more No Shows or Missed Appointments may result in the patient being released from care. We have the right to dismiss from care at any time.

*Exclusions to any Missed Appointments include death, severe illness, and as always, are at the discretion of the Abel Chiropractic Staff. We have the right to determine exclusions on a case-by-case basis.

I do agree to give the office notification of appointment rescheduling or cancellation 4 hours prior to my scheduled appointment. I understand that I am responsible for maintaining my appointment time & for proper notification of appointment changes and that if, for circumstances excluding emergencies I am unable to notify or fail to maintain my appointment that actions will be taken as described above including being charged a fee and/or dismissal from care.

Initial: ______

HIPAA: SUMMARY NOTICE OF PRIVACY PRACTICES

Please review this summary carefully. It describes how your medical information may be used and disclosed and how you can get access to this information.

Abel Chiropractic must maintain 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 this 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 and permitted under law.

Abel Chiropractic uses medical information about you for your treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive. Abel Chiropractic may use your information to provide appointment reminders, information about treatment alternatives, correspondence via email, voicemail, marketing/advertising and information about events and updates within Abel Chiropractic and/or related events, or other health related issues, etc. Abel Chiropractic may disclose your information when permitted or required by law.

Abel Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Initial: ______

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Abel Chiropractic Center is not required to agree to the restrictions that I may request. However, if Abel Chiropractic Center agrees to a restriction that I request, the restriction is binding on Dr. Karly Kantarevic and Abel Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Abel Chiropractic has taken action reliant on the consent.

I understand I have a right to review Abel Chiropractic's Notice of Privacy Practices prior to signing this document. This can be found online or reviewed as a hard copy at the Practice. The Notice of Privacy Practices describes my rights and the duties of Abel Chiropractic with respect to my protected health information. Abel Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

To obtain more information about your privacy rights you may contact our Privacy and Security officer Dr. Karly Kantarevic at Abel Chiropractic. You may also file a complaint with us or with the Secretary for Health & Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file. While you may make oral complaints at any time, written comments should be addressed to the Compliance Officer, Dr. Karly Kantarevic, at the address shown at the top of the page.

I consent to the use or disclosure of my protected health information by Abel Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Abel Chiropractic.

Initial: ______

Thank you for allowing us to be a part of your health care team! We appreciate your understanding & support.
I have read or have had read to me, understand, & consent to Abel Chiropractic's Terms & Conditions.

Patient Name: ______________________________

Patient or Guardian's Signature ______________________________ Date ______________