Today's Date:_____ Date of Injury:_____

Patient Name:_____ Date of Birth:_____ Age:____ Name of Spouse:_____
Address:_____City:_____State:_____Zip:_____Email:_____
Phone H:_____C:_____Work:_____Spouse's Phone:_____
Occupation:_____ Primary Care Physician:_____

Date of Accident:_____ Time of Accident:_____ Were you the driver or passenger?_____
Your Car Insurance Company:_____Phone:_____Claim Number:_____
Claims Mailing Address: Claims Representative Name:_____
_____ Email:_____
_____ Fax:_____
_____
Driver of the other automobile:_____ Name of their Insurance:_____
Their Insurance Phone Number:_____Representative Name:_____
Claim Number:_____

Were you aware of the approaching collision prior to impact, or was it a surprise?_____
Did you lose consciousness upon impact?____ Did you experience a flash of light, or explosion in your head?_____
Did the police come to the scene?_____ Is there a police report?_____ Did you go to the hospital?_____
Were x-rays taken?_____ Were any other doctors consulted after your accident?_____Name:_____
Were you wearing a seatbelt?_____ If yes, was there any injury or bruising from your seatbelt?_____
Were the airbags deployed?_____Did you hit your head on the headrest during the accident?_____
Which way was your head? Straight / Turned to Right / Turned to Left Body? Straight / Right / Left
How fast were you traveling at impact?_____ How fast was the other vehicle going?_____
Were you T-Boned / Rear-Ended / or Did you collide with the other car from the front?
Please describe what happened during the accident to the best of your ability.
_____ You may draw the accident here:
_____
_____
_____
_____
_____
_____
At the time of the accident, did you become or experience any of the following? __Confusion __Disoriented
__Light Headed __Dizzy __Nauseated __Ringing/Buzzing in Ears __Loss of Balance __Other_____

Check the symptoms you have noticed since the accident:

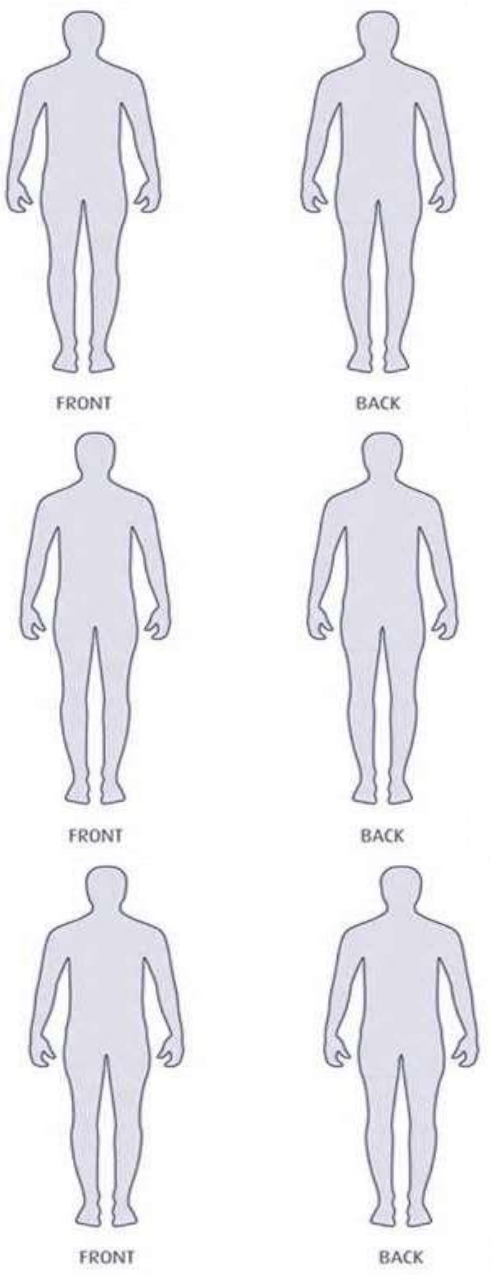
__Headaches/Migraines
__Low Back Pain
__Dizziness
__Loss of Smell
__Pinched Nerve
__Fever
__Paralysis
__Difficulty Swallowing
__Neck Pain
__Depression
__Fatigue
__Irritability
__Loss of Sleep
__Sciatica
__Upper Back Pain
__Buzzing in Ears
__Loss of Memory
__Digestive Problems
__Loss of Balance
__Vision Problems
__Fainting
__Sinus Pain
__Shoulder Pain
__Arm/Leg Pain
__Cold Hands/Feet
__Joint Pain/Stiffness
__Sore Muscles
__Mid Back Pain
__Jaw Pain/Clicking
__Numbness/Tingling
__Light Sensitivity
__Sleeping Problems
__Stomach Upset
__Head Feels Too Heavy
__Tension
__Pins/Needles Feeling
__Nervousness
__Chest Pain

Name:_____ Date of Injury:_____

CHIEF COMPLAINT

SECONDARY COMPLAINT

THIRD COMPLAINT



I understand that I am responsible to Rabo Health and Wellness for all services rendered. Rabo Health and Wellness agrees to bill my auto insurance company, and issue records to my attorney, if I have attained one. I understand that I will be responsible for a $35 copay per visit if I have Med-pay benefits through my insurance. Once insurance has paid the doctoring full, all my co-pays will be returned to me. For third party liability claims, insurance pays me, so I realize I am responsible for my services here.

I understand the information within this form, and I have completed it correctly and to the best of my knowledge.

_____ _____

Patient Signature Date

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES OF RABO HEALTH AND WELLNESS

I herby acknowledge that I have been provided for review a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices in the future.
Rabo health and Wellness may mail to my home or other designated location any items that assist them in carrying out treatment, payment, and health care operations, such as appointment reminders, and billing items and laboratory results, among others, relating to my care.
(Please Initial) _____ Yes _____ No

Rabo Health and Wellness may call my home or other designated location and leave a message or voicemail in reference to any items that assist them in carrying out treatment payment and healthcare operations, such as appointment reminders, insurance and billing items and laboratory results, among others, relating to my care.
(Please Initial) _____ Yes _____ No

I understand that I may revoke the above consent at any time in the future in writing.

Signed _____ Print _____ Date _____

Rabo Health and Wellness
TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully
(Print name)
understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Please bring the following with you to your appointment:

- A copy of your automobile insurance card.
- The claim representative's name and phone number.
- Your claim number.
- The police report. (If you have it yet)
- The name of your attorney and phone number, if you have one.