Today's Date:_____ Date of Injury:_____

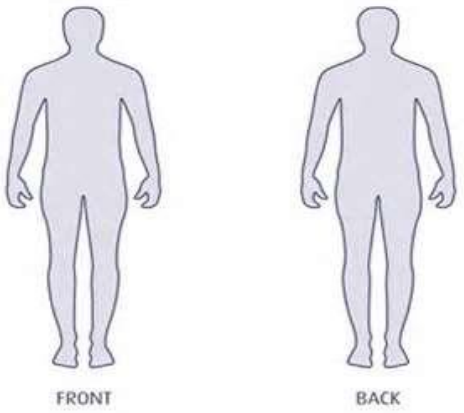
Patient Name:_____ Date of Birth:_____ Age:____ Name of Spouse:_____
Address:_____City:_____State:_____Zip:_____Email:_____
Phone H:_____C:_____Work:_____Spouse's Phone:_____
SSN:_____Occupation:_____Primary Care Physician:_____
Who may we thank for referring you to our office?_____ Have you ever had chiropractic care before?__

Check the symptoms you have noticed:

__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

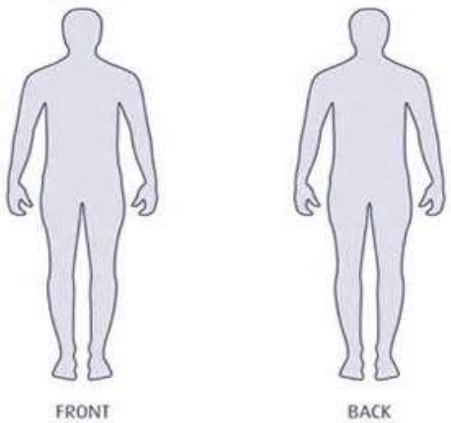
CHIEF COMPLAINT

_____
_____
_____
_____
_____
_____
How long has it hurt?_____



SECONDARY COMPLAINTS

_____
_____
_____
_____
_____
_____
How long has it hurt?_____



Check any of the following symptoms you have had in the last 6 months.

__headaches __numbness __sinus congestion/allergies __frequent nausea/vomiting

__vision problems __dizziness __abdominal cramps __ear aches

__constipation __diarrhea __poor or excessive appetite __excessive thirst

__heart problems __lung problems __congestion __blood pressure problems

__ankle swelling __discolored urine __painful or excessive urination __prostate/sexual dysfunction

__diabetes __cancer __menstral dysfunction

Are you pregnant? __yes __no __not sure

Do you smoke or chew tobacco?_____
Do you drink alcohol? _____

Current Medications; prescription, OTC, vitamins:

_____
_____
_____
_____

Due to the changes in health insurance fees, it is our policy that all payment is due at the time of service. We will courtesy bill your insurance company, but any payment the insurance company pays, will be sent directly to you, and will not be sent to Rabo Health and Wellness. We will provide a courtesy benefits check for you, but reimbursement from your insurance company is between you and and them.

The consultation with Dr. Rabo is free. If you decide to proceed with care, the initial examination is $71, and full spine x-rays are $210. The total cost payable today will be $281. This cost will include the report of findings on your second appointment.

I authorize Rabo Health and Wellness to render any necessary services to me, and I am responsible for all charges incurred.

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

_____ _____
Patient Signature Date

_____ _____
Guardian's Signature Authorizing Care 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)