Date of Visit: ____________

AGADA
CHIROPRACTIC &
INTEGRATIVE HEALTH CENTER

PERSONAL INFORMATION

Name:____Age:___________DOB:___________

Address:____City/State/Zip:_______________

Home Phone:________________ Work Phone:_________________ Cell Phone:_______________

Email Address:____

Male: ☐ Female: ☐ Emergency contact:______________________________

Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐

Occupation:____________________________

Children, Names & Ages:

____ __________________________________

____ __________________________________

YOUR HEALTH:

Reason For Seeking Chiropractic Care:

Activities you enjoy / Do your current symptoms limit you from doing them? (goals of treatment)

Please rate the following on a scale of 1-10 (1 = poor, 10 = excellent)

Where do you see your health?

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

Where would you LIKE to be?

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

3311 County Road 101 Suite 2 Minnetonka, MN 55391
Phone: 952-405-6263 Fax: 952-406-8060
www.agadachiropractic.com

Dr. Jean M. Ciola
Chiropractor

Please rate the following on a scale of 1-10 (1 = poor, 10 = excellent)

Mind-Set

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

General Health

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

Eating Habits

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

Exercise Habits

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

Sleep

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

Please rate the following on a scale of 1-10 (1 = none, 10 = extreme)

Occupational Stress

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

Personal Stress

1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐ 8: ☐ 9: ☐ 10: ☐

FAMILY HISTORY

Heart Disease

Arthritis

Cancer

Diabetes

Other______________________

SIGNIFICANT PAST MEDICAL HISTORY

Please list any past surgeries/ hospitalizations

Please list any past auto accidents, work-related injuries, or other significant injuries

Please list all medications you are taking and why

Agada Chiropractic - Office Policies and Privacy Statement

The following is a statement of our policies.
We require that you read, agree to, and sign prior to any care in our office.

CASH OFFICE
Your initial visit consists of a complete history, orthopedic, neurologic, and chiropractic examination, nervous system scans and full spine x-rays. The cost of this service is $95 unless otherwise arranged. Full payment is expected at the time of the dated service.

FINANCIAL POLICY
You assume financial responsibility for the care given. Outstanding balances will be billed monthly and considered past due 30 days after the invoice date. All past due balances are subject to a $5 late fee. Balances beyond 120 days may be directed to a third party collections agency. At this time, a 30% increase to your total bill will be added to cover the collection fees. If you need to make financial arrangements other than those listed above, you must contact our office promptly for assistance in the management of your account.

MISSED APPOINTMENTS
It is very important to your care plan that you keep your scheduled appointments. We realize that things come up. We will do our best to reschedule you at a time that is convenient for you. However, please contact us as soon as possible, so that we may schedule another patient during that time. If you miss 3 appointments without notice, your account will be billed for the date of the 3rd missed appointment.

CONSENT TO USE OR DISCLOSURE OF HEALTH INFORMATION AT Agada Chiropractic:

Our Privacy Pledge
There are several circumstances in which we may have to use or disclose your health care information:
We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. We may need to use your health information within our practice for quality control or other operational purposes. We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

Your right to limit uses or disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization
You may revoke your consent to us at any time in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read and fully understand the above policies:
I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this authorization.

Printed name ____

Signature ____________________________________ Date___________________________

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