Welcome to Active Body Chiropractic!

DATE: _____

First Name: _____ Last Name: _____ Middle Initial: _____
Date of Birth: ___/___/____
Gender (circle one): Male / Female
Social Security Number: _____ (required for insurance patients)

Current Home Address: _____
City: _____ State: _____ Zip Code: _____

Contact Info: Home phone:_____ Cell phone: _____
Work phone: _____
E-mail address: _____

Current marital status? (Single, Married or Other): _____
Occupation: _____ Employer:_____

How did you find us? Please help us out by describing how you found out about our clinic. If it was a friend, who was it? If you found us on the internet, on which search engine or website did you find us? This information is greatly appreciated!

_____

Health Insurance Patients: We need your current insurance card and a photo identification card. *If this insurance is not under your name, please enter the following:*

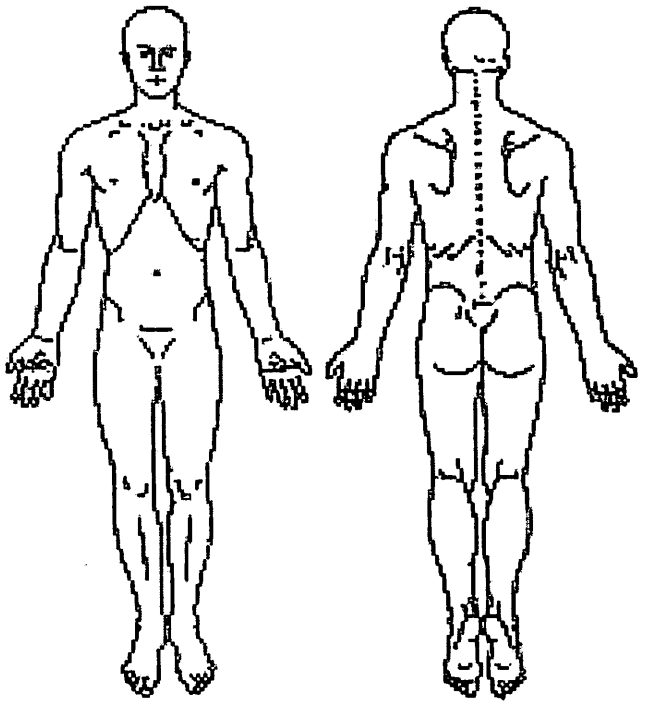
Name of the Insurance Holder:_____ Relation to Patient:_____

Date of Birth of the Insured: _____

Other Payment Methods for Services:

- ❑ Self Pay: credit card, check or cash accepted; **payment due at time of service.**
- ❑ Auto Accident / Worker's Comp: we may accept assignment for these cases.

Please draw on this diagram any areas of the body that are of concern to you:



<u>Describe</u> each of your areas of pain or discomfort on the lines below. Please <u>place a mark on the severity line</u> between 0 and 10 to indicate how severe the symptom typically is:

1st Complaint Area:_____

Severity: _____

0 (no pain) **5** **10** (severe pain)

2nd Complaint Area:_____

Severity: _____

0 (no pain) **5** **10** (severe pain)

How and when did these pains begin? Did these pains begin on a specific date, or was there a gradual onset? Is there a specific injury that brought on these pains?

_____

_____

_____

_____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____

• Please indicate any of the following activities that **AGGRAVATE YOUR PAIN**:

❑BENDING ❑REACHING ❑COUGHING ❑SITTING ❑LYING DOWN
❑LIFTING ❑SNEEZING ❑WALKING ❑STANDING
❑MOVEMENT OF THE AREA ❑OTHER_____
_____

• Please indicate any of the following activities that **RELIEVE YOUR PAIN**:

❑RESTING ❑STRETCHING ❑WALKING ❑SITTING ❑LYING DOWN
❑STANDING ❑IBUPROFEN / MEDICATIONS ❑ICE ❑HEAT
❑MOVEMENT HELPS ❑OTHER_____
_____

• Please indicate any additional symptoms you are **CURRENTLY** experiencing:

❑blurred vision	❑cold hands	❑upset stomach	❑fever
❑buzzing in ears	❑cold sweats	❑dizziness	❑fainting
❑headaches	❑cold feet	❑constipation	❑diarrhea
❑fatigue	❑insomnia	❑light bothers eyes	❑loss of balance
❑loss of smell	❑loss of taste	❑muscle jerking	❑numbness in fingers
❑numbness in toes	❑ringing in ears	❑shortness of breath	❑stiff neck
❑pins and needles in arms		❑pins and needles in legs	
❑concentration loss/confusion		❑depression/weeping spells	
❑head seems too heavy		❑low resistance to colds	

Bruising /Bleeding Abnormalities: Do you have any systemic conditions such as platelet function problems or any other bleeding disorders? Are you currently taking any medications, such as coumadin, that cause easy bruising? These conditions may preclude you from receiving deep tissue work, so we need to know about them before we render therapy.

❑No bruising / bleeding disorder or medications.
❑Yes, this may describe me! (Consult with your treating doctor.)

•**Do you smoke?** ❑**Never**
- ❑Current smoker
- ❑Past smoker
- ❑Occasional smoker
- **Smoking start date:** _____

•Are you currently pregnant or think you may be pregnant? ❑No ❑Yes

Do you have any allergies (medications, plants, foods)?

Allergic to:	Reaction	Onset Date	Additional Comments

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

FAMILY HISTORY: To the best of your knowledge, please indicate which PAST or PRESENT conditions have been experienced by yourself, your mother, or your father by marking appropriate boxes.

S = Self M = Mother F = Father

S	*M*	*F*		*S*	*M*	*F*		*S*	*M*	*F*	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	convulsions
❑	❑	❑	cramps	❑	❑	❑	sinus trouble	❑	❑	❑	diabetes
❑	❑	❑	MS	❑	❑	❑	stroke	❑	❑	❑	indigestion

SURGICAL HISTORY: Please indicate any major surgeries and their approximate dates.

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

Do you have any metal objects or surgical devices in your body? ❑No ❑Yes

ACCIDENT HISTORY: Please describe any automobile or other major accidents you have been involved in and their approximate dates:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

STATEMENT of AUTHORIZATION / UNDERSTANDING
and ASSIGNMENT of BENEFITS
(Please read carefully before signing.)

I, the undersigned, hereby authorize the staff of Active Body to perform such services as deemed necessary by the physician to diagnose and treat my condition(s).

I authorize assignment of my insurance rights and benefits directly to this provider in order to pay for my medical bills. I also authorize the release of such information as is needed to process insurance claims by provider or agent.

I understand that I am responsible for the payment of all co-pays and deductibles associated with my insurance plan; and, in the event of non-payment by my insurance company, I understand that I am responsible for all medical bills incurred at Active Body. Active Body will not be held accountable for mis-information regarding my insurance benefits and coverage. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account.

I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

SIGNATURE of Patient (or Guardian):

X _____