



WELCOME!

Today's Date: ____ / ____ / ____

Your Name: _____ Male Female

Date of Birth: ____ / ____ / ____ Age: ____ Social Security #: ____-____-____

Insurance Provider: _____ Provider Phone Number: ____-____-____

ID Number: _____ Group Number: _____

Marital Status: Single Married Divorced Widowed Separated

Home Address: _____ Unit Number: _____

City: _____ State: _____ Zip: _____

Mobile Phone: ____-____-____ Home Phone: ____-____-____

Work Phone: ____-____-____ E-mail: _____ (Personal Work)

Appointment Reminders Via: Text Message Phone Call E-mail

Employer: _____

Work Address: _____ Unit Number: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Emergency Contact: _____ Phone: ____-____-____

How did you hear about us: _____

(If someone referred you, let us know so we can thank them!)

Thank you for choosing ProACTIVE Chiropractic!

Help us spread the wellness by referring your friends and family.

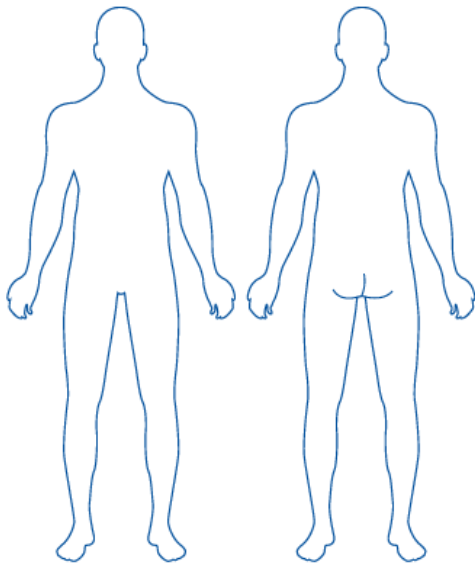


INTAKE FORM

Your Name: _____ Today's Date: ____ / ____ / ____

Height: ____' ____" Weight: _____ lbs. Age: ____ Occupation: _____

Indicate (with an 'X') on the drawings below where you have pain/ symptoms



I experience pain/ symptoms:

Constantly (76-100% of the time)

Frequently (51-75% of the time)

Occasionally (26-50% of the time)

Intermittently (1-25% of the time)

Doctor's Notes

The type of pain I am experiencing is:

Sharp Sharp with motion Stabbing Stabbing with motion

Achy Dull Tingling Shooting Shooting with motion

Stiff Throbbing Burning Numbness Weakness

(leave blank, for office use)

My symptoms are: Getting worse Staying the same Getting Better

I have been experiencing this problem for ____ Days Weeks Months Years

This problem interferes with my work: Never A little Moderately A lot Constantly

This problem interferes with my social activities: Never A little Moderately A lot Constantly

For this condition I have also seen:

Chiropractor Neurologist Primary Care Physician ER Physician Orthopedist

Massage Therapist Physical Therapist No one Other: _____

I've tried the following treatments to alleviate the problem:



For each condition below place a check in the past or present column if you have had or currently have any of the conditions:

	past	present		past	present
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Mid-Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Dermatitis/ Rash	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
HIV/ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Drug Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>

I would rate my overall health: Excellent Great Good Fair Poor

I take the following prescribed medications: _____

I take the following over-the-counter medications: _____

I take the following dietary supplements: _____

I've had the following surgical procedures: _____

I have been hospitalized: No Yes, for: _____

I have had significant past trauma: No Yes: _____

An immediate family member of mine has:

Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS/MS



My exercise regimen is: Strenuous Moderate Light None

The amount of water I drink daily is: 8 oz. or less 16-32 oz. 32-64 oz. 64 oz. +

The amount of soda/ coffee I drink daily: 1 cup or less 2-3 cups 4 cups +

At work I perform these activities:

Sit: Most of the day Half the day A little of the day

Stand: Most of the day Half the day A little of the day

Computer work: Most of the day Half the day A little of the day

On the phone: Most of the day Half the day A little of the day

Other information pertinent to my visit: _____

My treatment goals are:

Simply get out of pain

Get out of pain AND address the cause

Get out of pain, address the cause, and achieve optimal wellness

Patient Signature: _____ Date: __ / __ / ____



CONSENT TO CARE HIPPA/ ASSIGNMENT OF BENEFITS

This form contains how your Protected Health Information (PHI) will be used in our office. By signing at the end of these policies, you agree to all stipulations.

1. The patient understands and agrees to allow ProACTIVE Chiropractic & Physiotherapy to use their PHI for the purpose of treatment, payment, health care operations and coordination of care.
2. The patient has the right to their exam and to obtain a copy of his/her own health records at any time and request corrections. The patient may request the disclosures that have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient at this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by ProACTIVE Chiropractic & Physiotherapy to assure that your records are not readily available to those who do not need to see them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse care.

Authorization, Assignments of Benefits and Consent to Treat To: ProACTIVE Chiropractic & Physiotherapy Doctors, hereafter referred to as OFFICE:

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as may be due and owing the OFFICE, of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement.
2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and it may be necessary for the OFFICE to record a lien on my case to ensure payment, and I agree to pay the charges associated with filing of the lien.
4. I understand that, if necessary, the OFFICE may employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.
5. I agree that the OFFICE has the right to call my home or place of employment regarding appointment and/or insurance issues.
6. I give permission to the office to send me birthday, holiday-related, and thank you cards or gifts, call me and/or leave messages for me on an answering machine/voice mail, provide me information on treatment and other health related information, allow staff and other patients to view my name on the sign in register, treat me in an open room where others may see me, within reason and comfort level.
7. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, nutritional assessment and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic, the office staff, and/or licensed doctors of chiropractic while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.
8. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, stroke, dislocations and sprains. I do wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, as in my best interest.
9. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about it, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
10. A photocopy of this form shall be valid as original.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: _____

Date: __ / __ / ____

Guardian Signature (If patient is a minor): _____

Date: __ / __ / ____

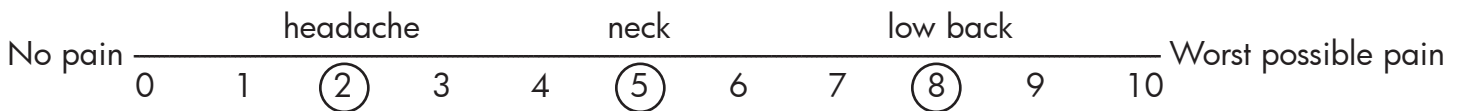


PAIN SCALE

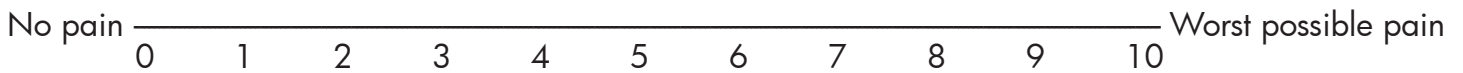
Your Name: _____ Today's Date: ___ / ___ / _____

Please circle the number that best describes the question being asked and label the pain. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

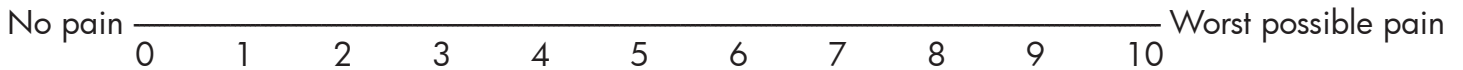
Example:



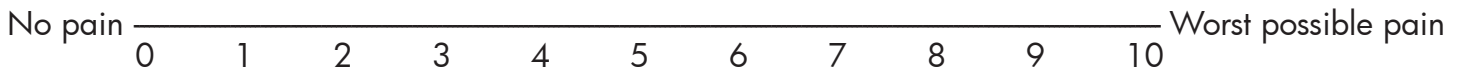
What is your pain right now?



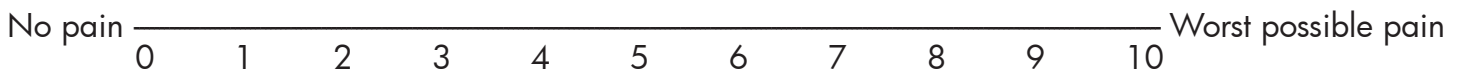
What is your typical or average pain?



What is your pain level at its best?



What is your pain level at its worst?



Comments: _____

