

Patient Data**Date:** _____**Title:** Mr. Mrs. Ms Miss (check one)**First Name:** _____ **Middle Initial:** _____ **Last Name:** _____**Address Line 1:** _____**Address Line 2:** _____**City:** _____ **State:** _____ **Zip Code:** _____**Home Phone:** (_____) _____ - _____ **Work Phone:** (_____) _____ - _____**Cell Phone:** (_____) _____ - _____**Date of Birth:** ____/____/____ **Sex:** Male Female **Email:** _____**Social Security Number:** _____ - _____ - _____ **Marital Status:** Single Married Other**Employment Status:** Employed Full Time Student Part Time Student Other (check one)**Spouse Data****Is your spouse a patient in the clinic?** Yes No**First Name:** _____ **Middle Initial:** _____ **Last Name:** _____**Home Phone:** (_____) _____ - _____ **Work Phone:** (_____) _____ - _____**Employer Data****Name:** _____**Address Line 1:** _____**Address Line 2:** _____**City:** _____ **State:** _____ **Zip Code:** _____**Emergency Contact****Contact Name:** _____**Contact Phone:** (_____) _____ - _____

Is it okay to call you at work?

- Yes No

How did you hear about our clinic? Or who referred you?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> Other |

If you selected 'Yellow Pages' please indicate which Yellow Pages:

If you selected 'family member', 'friend', or 'physician' please enter their name below:

If you selected 'other' please describe

Medical Conditions:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Other _____ | |

Surgeries:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies | <input type="checkbox"/> Radical prostatectomy | <input type="checkbox"/> Transurethral prostate surgery |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Other _____ | |

Allergies:

- | | | | |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Gluten | <input type="checkbox"/> Other _____ |

Social History:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always | <input type="checkbox"/> Wear seat belts never | <input type="checkbox"/> Wear seatbelts usually |

Family History:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent) | <input type="checkbox"/> Arthritis (sibling) | <input type="checkbox"/> Cancer (parent) | <input type="checkbox"/> Cancer (sibling) |
| <input type="checkbox"/> Cholesterol (parent) | <input type="checkbox"/> Cholesterol (sibling) | <input type="checkbox"/> Diabetes (parent) | <input type="checkbox"/> Diabetes (sibling) |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent) | <input type="checkbox"/> Psychiatric (sibling) | <input type="checkbox"/> Stroke (parent) | <input type="checkbox"/> Stroke (sibling) |
| <input type="checkbox"/> Thyroid (parent) | <input type="checkbox"/> Thyroid (sibling) | <input type="checkbox"/> Other _____ | |

Substance Use:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past) | <input type="checkbox"/> Heroin (Present) |
| <input type="checkbox"/> Marijuana (past) | <input type="checkbox"/> Marijuana (present) | <input type="checkbox"/> Other _____ | |

Male Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Female Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Occupational Activities:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare/childcare | <input type="checkbox"/> Executive/legal | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |
| <input type="checkbox"/> Military | <input type="checkbox"/> Police/fire | <input type="checkbox"/> Professional Service | <input type="checkbox"/> Teacher |

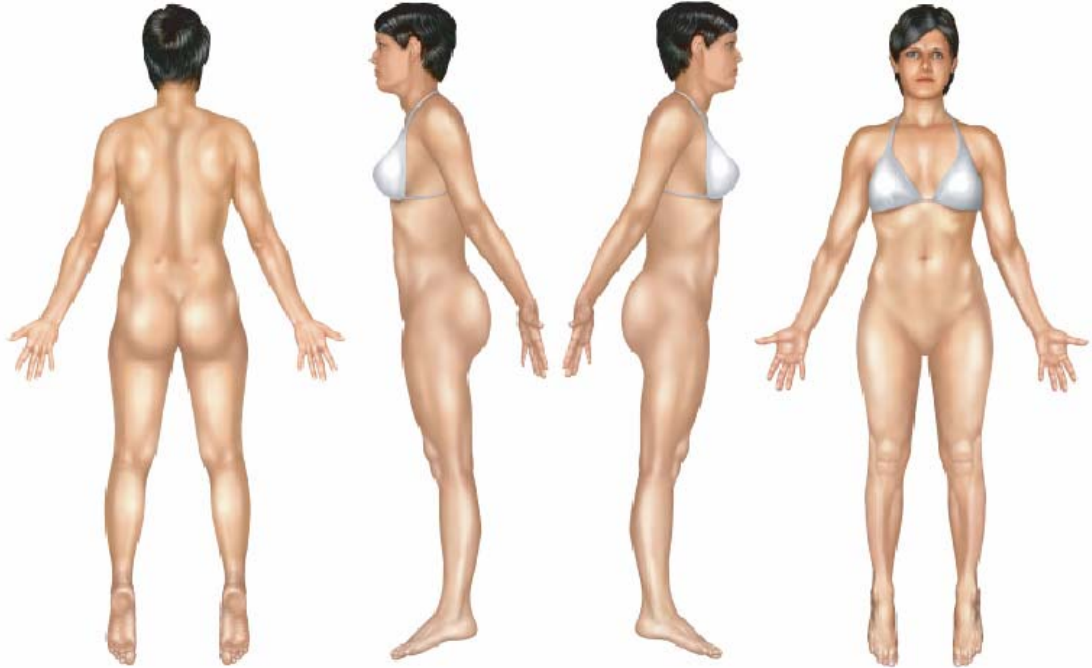
Truck driver Other _____

Recreational Activities:

- | | | | |
|--------------------------------------|---|--|-----------------------------------|
| <input type="checkbox"/> Backpacking | <input type="checkbox"/> Biking | <input type="checkbox"/> Boating | <input type="checkbox"/> Football |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Racket ball | <input type="checkbox"/> Rock climbing | <input type="checkbox"/> Running |
| <input type="checkbox"/> Skiing | <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Weight lifting | <input type="checkbox"/> Other _____ | |

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache



Describe your symptoms: _____

When did your symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Constantly
(76-100% of the day) | <input type="checkbox"/> Frequently
(51-75% of the day) | <input type="checkbox"/> Occasionally
(26-50% of the day) | <input type="checkbox"/> Intermittently
(0-25% of the day) |
|---|--|--|---|

What describes the nature of your symptoms?

- | | | | |
|----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull ache | <input type="checkbox"/> Numb | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | |

How are your symptoms changing?

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Getting better | <input type="checkbox"/> Not changing | <input type="checkbox"/> Getting worse |
|---|---------------------------------------|--|

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- | | | | |
|---------------------------------|----------------------------|--|----------------------------|
| <input type="checkbox"/> 0 None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 |
| <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 Unbearable | |

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- Not at all A little bit Moderately Quite a bit
 Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- All of the time Most of the time Some of the time A little of the time
 None of the time

In general, would you say your overall health right now is....

- Excellent Very good Good Fair
 Poor

Who have you seen for your symptoms:

- No one Other Chiropractor Medical Doctor Physical Therapist
 Other _____

What treatment did you receive for your symptoms?

- Adjustments Physical Therapy Medication Surgery
 Other _____

When did you receive this treatment?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 – 2 years ago 2 – 5 years ago 5 – 10 years ago

What tests have you had for your symptoms?

- X-rays MRI CT Scan Other _____

When were these tests done?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 - 2 years ago 2 – 5 years ago 5 – 10 years ago

Have you had similar symptoms in the past?

- Yes No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- This Office Other Chiropractor Medical Doctor Physical Therapist
 Other _____

What is your occupation?

- Professional/Executive White Collar/Secretarial Tradesperson Laborer
 Homemaker Full-time Student Retired Other

If you are not retired, a homemaker or a student, what is your work status?

- Full-time Part-time Self-employed Unemployed
 Off work Other _____

Thank you. Please return to the front desk.

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:

	No _____		
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary:

	No _____		
	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/Lymphatic:

	No _____		
	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic:

	No _____		
	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory:

	No _____		
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat:

	No _____		
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes:

	No _____		
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary:

	No _____		
	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric:

	No _____		
	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional:

	No _____		
	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic:

	No _____		
	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal:

	No _____		
	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal:

	No _____		
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine:

	No _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			



8711 Windsor Parkway, Suite 7
Johnston, IA, 50131

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments, physical examinations, and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible).

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, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, 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 for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient Name _____ (Please Print) Signature of Patient _____

Date Signed _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR

Signature of Representative _____ Date Signed _____

Relationship or Authority of Patient's Representative _____



Insurance Consent

Welcome to Active Wellness Chiropractic & Rehabilitation! We are delighted that you chose our office to care for you. Our goal is to treat patients of all ages with different needs and we use our best efforts to make your experience as pleasant as possible.

Please be aware that even if you have insurance, your account is your responsibility, NOT that of your insurance company. Before or during your initial visit, we contact your insurance company to get benefit information. The representative or online system immediately reads us a disclaimer that they do not guarantee payment and that payment is based on the plan booklet that you received. We urge you to be fully aware of the provisions of your policy, as we are NOT responsible for any errors, omissions or misinformation given to us by your insurance company. Your estimated percentage for procedures will be collected at the date of service. Some insurance companies may "DOWNCODE" the procedures, meaning their reviewer somehow decides the degree of difficulty is less than what was performed. This is their way of paying even less on your claim. We are most willing to appeal per your request. Although we do our best to provide the most accurate information to you, it is possible you may owe money after your insurance has paid. We ask the balance be paid upon receipt of your billing statement.

Please feel free to call us with any questions. We look forward to working with you and will do our best to meet your needs.

Thank you,

Active Wellness Team

Signature: _____ Date _____



Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, “I” and “my” refer to the patient,
and “Chiropractor” refers to Active Wellness Chiropractic & Rehabilitation.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.
I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at [insert address of Chiropractic practice]. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative’s Authority