



ACTIVE LIFE CHIROPRACTIC

12920 Lebanon Rd. Ste 1 Mt Juliet, TN 37122
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Patient Profile

Full Name: _____ **Preferred name:** _____ **Birthdate:** ____/____/____
mm dd yy

Address: _____ **Social Security*:** _____
Street Address City / State / Zip Code * insurance patients only

Phone: _____ **Emergency Contact:** _____
Name Phone

Email Address: _____ **Employer:** _____ **Occupation:** _____

Marital Status: Single Married Widowed Divorced **Referred By:** _____

Health insurance? No Yes **If yes, Insurance Company:** _____ **Responsible party:** Parent Other: _____

Health savings account account? No Yes **Primary Care Doctor:** _____

Health History I

List of prescriptions, over-the-counter medications, vitamins or supplements you currently take:

List surgeries and approximate date:

Implants, screws, plates, or other foreign objects?

Do you: Exercise Allergies _____
 Smoke _____
frequency

Have you ever been diagnosed with cancer:

No Yes: _____
type

Date of most recent: (mm/yy)

CT Scan: _____ MRI: _____ Spinal Xray: _____

For Women Only:

Pregnant **N Y** Last menstrual cycle _____
 Given birth? **N Y** How many times? _____

Reason for Visit

Reason for your visit: _____

Activities unable to perform: _____

When did the symptoms begin: _____

Have you received chiropractic care before? N Y

Reason _____ How long _____

Why was care stopped? _____

Which word describes the frequency of your discomfort?

Constant Intermittent Frequent Occasional

When is the pain worst?

Morning Afternoon Night No change

What helps relieve the pain?

Medication Heat Ice Nothing Other _____

What causes discomfort during the day? Select all that apply

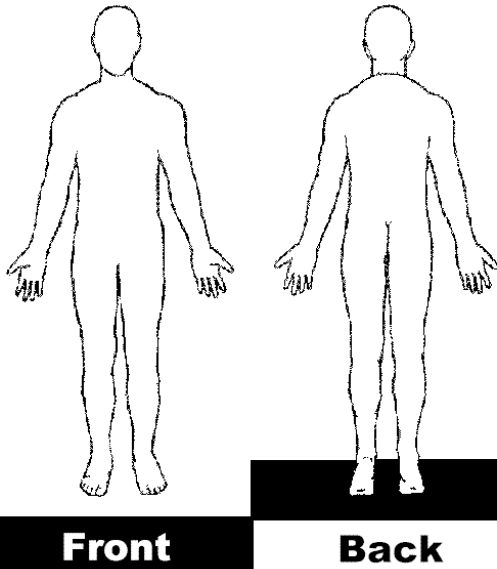
Bending Getting up Reading Lifting
 Turning head Sitting Pulling Pushing
 Urination Sneezing Coughing Driving
 Lying Down Standing Sleeping Walking
 Working Bowel Movement Other _____

Health History II

Do you currently or have you previously had any of the following symptoms?

<p>Current Previous</p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Ringing in Ears</p> <p><input type="checkbox"/> <input type="checkbox"/> Digestive Issues</p> <p><input type="checkbox"/> <input type="checkbox"/> Swelling in Joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiating Arm/Hand Symptoms</p>	<p>Current Previous</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty Urinating</p> <p><input type="checkbox"/> <input type="checkbox"/> Sudden Weight Loss</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p>	<p>Current Previous</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Shoulder Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Feet/Hands Cold</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiating Leg/Foot Symptoms</p>	<p>Current Previous</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Leg Cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p>
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Patient System Illustrator



Instructions:

- Using diagram (left), circle affected body part(s).
- Below describe the affected body part pain and rate the severity of pain in affected area.

1) **Affected Body Part:** _____ **Side:** L R **Severity of pain:** 1 2 3 4 5 6 7 8 9 10

Symptom(s): Burning Sharp Stabbing Numbness Spasm Stiffness
 Dull Ache Throbbing Pins & Needles Swelling

2) **Affected Body Part:** _____ **Side:** L R **Severity of pain:** 1 2 3 4 5 6 7 8 9 10

Symptom(s): Burning Sharp Stabbing Numbness Spasm Stiffness
 Dull Ache Throbbing Pins & Needles Swelling

3) **Affected Body Part:** _____ **Side:** L R **Severity of pain:** 1 2 3 4 5 6 7 8 9 10

Symptom(s): Burning Sharp Stabbing Numbness Spasm Stiffness
 Dull Ache Throbbing Pins & Needles Swelling

4) **Affected Body Part:** _____ **Side:** L R **Severity of pain:** 1 2 3 4 5 6 7 8 9 10

Symptom(s): Burning Sharp Stabbing Numbness Spasm Stiffness
 Dull Ache Throbbing Pins & Needles Swelling

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: <http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf>

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records The patient hereby assigns benefits to be paid directly to this provider by all of the third party payors. This assignment is irrevocable. Failure to fill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy The patient accepts full financial responsibility for services rendered by this practice. An account which is past due and for which no payment arrangements have been made will be forwarded to a collection agency. Collection agency fees will be the responsibility of the patient.

Initial _____

Patient Name

Patient Signature

Date

Parent/Guardian Name *if under 18*

Parent/Guardian Signature *if under 18*

Date