ACTIVE LIFE CHIROPRACTIC

12920 Lebanon Rd. Ste 1 Mt Juliet, TN 37122
(p) 615.758.7373 (f) 615.827.0010

Patient Profile

Full 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? _____

Health History II

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

Current	Previous		Current	Previous	
☐	☐	Pacemaker	☐	☐	Nervousness
☐	☐	Sinus Problems	☐	☐	Neck Pain
☐	☐	Ringing in Ears	☐	☐	Back Pain
☐	☐	Digestive Issues	☐	☐	Shoulder Pain
☐	☐	Swelling in Joints	☐	☐	High Blood Pressure
☐	☐	Sleep Problems	☐	☐	Headaches
☐	☐	Depression	☐	☐	Diabetes
☐	☐	Difficulty Urinating	☐	☐	Leg Cramps
☐	☐	Sudden Weight Loss	☐	☐	Dizziness
☐	☐	Feet/Hands Cold			
☐	☐	Radiating Arm/Hand Symptoms			
☐	☐	Radiating Leg/Foot Symptoms			

Reason for Visit

Reason for your visit: _____ Activities unable to perform: _____

When did the symptoms begin: _____

Previously received chiropractic care? N Y Reason _____ How long _____ Why was care stopped? _____

Which describes the frequency of your discomfort? ☐ Constant ☐ Intermittent ☐ Frequent ☐ Occasional

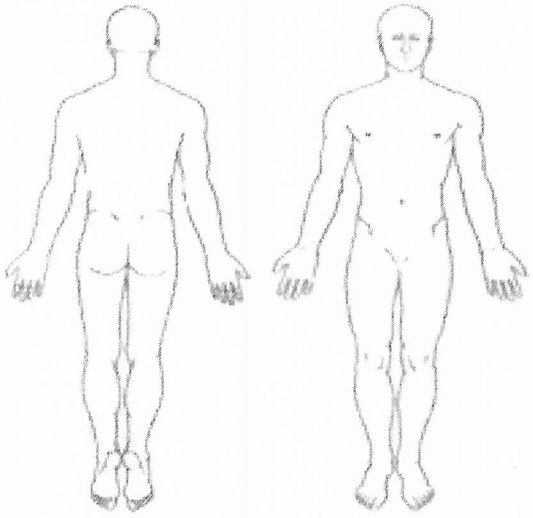
When is the pain worst? ☐ Morning ☐ Afternoon ☐ Night ☐ No change

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 _____

Patient System Illustrator



Instructions:

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

1) Affected Body Part: _____ Side: L R Symptom(s): ☐ Burning ☐ Swelling ☐ Numbness ☐ Spasm ☐ Pins & Needles ☐ Dull Ache ☐ Throbbing ☐ Stiffness ☐ Sharp Stabbing

Severity of pain: 1 2 3 4 5 6 7 8 9 10

2) Affected Body Part: _____ Side: L R Symptom(s): ☐ Burning ☐ Swelling ☐ Numbness ☐ Spasm ☐ Pins & Needles ☐ Dull Ache ☐ Throbbing ☐ Stiffness ☐ Sharp Stabbing

Severity of pain: 1 2 3 4 5 6 7 8 9 10

3) Affected Body Part: _____ Side: L R Symptom(s): ☐ Burning ☐ Swelling ☐ Numbness ☐ Spasm ☐ Pins & Needles ☐ Dull Ache ☐ Throbbing ☐ Stiffness ☐ Sharp Stabbing

Severity of pain: 1 2 3 4 5 6 7 8 9 10

4) Affected Body Part: _____ Side: L R Symptom(s): ☐ Burning ☐ Swelling ☐ Numbness ☐ Spasm ☐ Pins & Needles ☐ Dull Ache ☐ Throbbing ☐ Stiffness ☐ Sharp Stabbing

Severity of pain: 1 2 3 4 5 6 7 8 9 10

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 (HIPPAA) 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 HIPPAA 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