

ACTIVE LIFESTYLES WELLNESS & PERFORMANCE CTR.

chiropractic, physical therapy & nutritional counseling

Dear _____,

We thank you for choosing our facility for your wellness needs. It is very important to us to deliver the best possible care to you and to all our clients. In trying to do so, we ask that you follow the plan of care given to you which includes your home exercise program and your scheduled appointments.

We strongly value timeliness in our office and we try to minimize waiting periods. We realize that your time is just as valuable as ours. Therefore we would like for you to respect our **24 hour cancellation policy** so we can schedule appointments most efficiently.

We value your business and the business you provide us with your referrals. If you are satisfied with our services, we encourage you to refer a friend or a loved one. Also, if you have any suggestions on how to improve our services please let us know.

Our mission is to provide the best care possible through chiropractic, physical therapy and supplement (vitamin) therapy. Dr. Res and his staff attends many seminars to assure that you get the best care possible. Ask about the latest ventures and he will be happy to share them with you.

The Doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease.

Thomas A. Edison

Best wishes of Health,
Your Healthcare Team at Active Lifestyles.

1715 37th Place, Third Floor, Vero Beach, FL, 32960.
772-978-7379, www.activelifestylesVB.com

To save time and allow us to better serve you, please complete all questions on the next pages. Thank you!

Personal History

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Birthdate: _____ Age: _____ Sex: M F
E-Mail: _____ Social Security # _____

Business/Employer: _____ Business Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Type of Work: _____

Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____
Spouse's Name: _____
Emergency Contact: _____ Phone Number: _____
Relationship: _____

How did you hear about our office? _____
Who may we thank for referring you to this office? _____

Current Health Condition

Current Complaint(s): _____
Other doctors seen for this condition? Yes No Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has the condition occurred before? Yes No
Is the condition: Job-related Auto-related Home Injury Fall Other: _____
Date of Accident: _____ Time of Accident: _____
What happened? _____

What aggravates your condition? Sitting Standing Bending Lifting Walking
 Lying Down Cold Dampness Other: _____
What relieves your condition? Bed Rest Ice Heat Massage Medication
 Other: _____

Is it getting: Worse Constant Comes/Goes Better
Character of Pain: Sharp Dull Ache Pins & Needles Numb Constant Burning

Does the pain radiate anywhere? No Arm (L or R) Leg (L or R)

Other: _____

When does it hurt? Morning Evening It wakes me up at night

Other: _____

Please describe how it feels when this problem is at its worse: _____

Place an X on the grade to indicate the severity of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 WORST

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:

Your ability to work? _____

Your ability to enjoy your family or your social time? _____

Your ability to enjoy your hobbies or sports? _____

At its worst, how old does this problem make you feel? _____

Do you suffer from any other condition than the one you are now consulting us for? _____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____

Have you had X-rays/ MRIs/ CT scans taken in the last six months?

If yes, where: _____

Past Health History

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other: _____

Previous: Childhood Traumas _____ Sports Injuries _____

Motor Vehicle Accidents _____ Work Injuries _____

Hospitalization (other than above): _____

Chiropractic Care/ Physical Therapy/ Acupuncture:

Have you ever had Chiropractic Care/ Physical Therapy/ or Acupuncture (circle) ? Y / N

If Yes, When?

Where?

For what condition? _____

Results: Excellent Good Fair Poor

Were X-rays taken? Yes No Not Sure

Technique used: _____

Medical Doctor:

Name: _____ Telephone: _____

Address: _____

Date of Last Appointment: _____ Date of Last Physical: _____

Are you currently under the care of a home health aide? YES / / NO / /

Have you had any Chiropractic or Physical therapy services this calendar year? YES / / NO / /

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? No Yes Whom? _____

Have your children ever had a spinal check-up? No Yes If yes, where and when?

Current Medications: _____

Current Vitamin Supplements: _____

Would you be interested in using vitamin supplements customized for your particular needs and/or to help counter-act the side-effects of your medications?

___ YES

___ NO

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.
Check any of the following you have had in the past six months:

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion / Depression
- Fainting
- Convulsions
- Cold / Tingling Extremities
- Stress

Musculo-Skeletal

- Low Back Pain
- Gas/Bloating After Meals
- Pain Between Shoulders
- Heartburn
- Neck Pain
- Black/Bloody Stool
- Arm Pain
- Colitis
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems**
- Dental Problems
- Sore Throats
- Ear Aches
- Hearing Difficulties
- Stuffed Nose

Genito-Urinary

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

Gastro-Intestinal

- Poor / Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Abdominal Cramps

Check any of the following diseases you have had:

- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Mental Disorder
- Anemia
- Heart Disease
- Lumbago
- Measles
- Thyroid
- Eczema

General

- Fatigue
- Loss of Sleep
- Fever
- Headaches
- Significant Weight Loss

Females Only

When was your last period?

Are you pregnant?

- Yes No Not Sure

Male / Female _____

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain / Infections
- Breast Pain / Lumps
- Prostate / Sexual Dysfunction

Lifestyle Stress Levels

- High
- Moderate
- Very Little

Intake

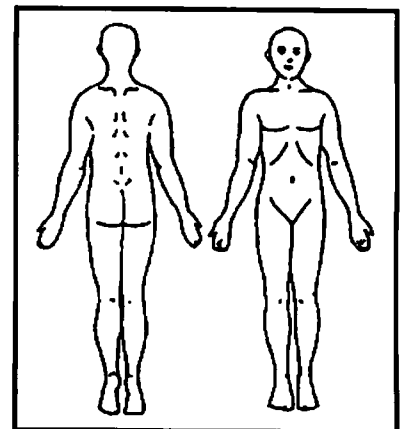
- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar
- Drugs

Satisfaction with Diet

- Highly Satisfied
- Dissatisfied
- Highly Dissatisfied

Do you have a regular exercise program?

- Yes
- No



Please outline on the diagram the area of your discomfort and any radiation of pain.

Fee Schedule (FOR THE MOST COMMON PROCEDURES ONLY)

Code	CPT	Description	Fee
AC-Eval		Initial Acupuncture Evaluation	\$190.00
AC-F/U		Acupuncture Follow-up	\$85.00
AH	99050	Services after hours	+ \$35.00
E-stim	97014	Electrical Stimulation Therapy	\$23.00
Elect	A4556	Electrodes for Therapy(2)	\$20.00
Ex-band	A9300	Exercise Band	\$12.00
Gait	97116	Gait Training Therapy	\$40.00(per 15 min.)
Hot/Co	97010	Hot/cold pack therapy	\$7.50
M-Ther	97140	Manual Therapy 1+ regions	\$42.00(per 15 min.)
MT-Hand	95832	Hand Dynamometer	\$39.00
MX1	98943	Manipulation Extraspinal, 1 or more regions	\$40.00
THER-EX	97110	Therapeutic Exercise	\$45.50 (per 15 min.)
NEURO	97112	Neuromuscular re-education	\$47.00 (per 15 min.)
NUT-AD	97802	Medical Nutritional Advice, initial	\$40.00 (per 15 min.)
OV10	99201	Office visit, Initial, Level 1	\$60.00
OV5	99211	Office visit, established patient, level 1, min	\$34.20
OV10	99241	Office consult, initial, level 1, FFS	\$85.00
PT-EVAL	97001	Physical Therapy evaluation	\$122.80
PT-RE	97002	Physical therapy re-assessment	\$64.80
RADJ	94667	Chest Wall manipulation, initial	\$34.00
RADJ-2	94668	Chest wall manipulation, subsequent visits	\$28.00
SM	98940	Spinal manipulation 1-2 regions	\$42.00
SM3	98941	Spinal manipulation, 3-4 regions	\$59.00
SM5	98942	Spinal Manipulation, 5 regions	\$72.00
US	97035	Ultrasound Therapy	\$20.00 (per 15 min.)
TGY	93740	Temperature Gradient Studies (Thermography)	\$35.00
LAZ	S8948	Laser treatment	\$50.00

MISSED or Cancelled Appointment (less than a 24 hour notice) \$40 (cannot be billed to insurance)

I understand that this is not a complete list of all the fees associated with this office and moreover, that insurance may not cover all these fees. Furthermore, I realize that I am ultimately responsible for paying all fees associated with my treatment here at Active Lifestyles Chiropractic, regardless if insurance pays for them or not. A complete fee schedule may be provided upon request.

(Signature)

(Date)

(Office staff witness)

(Date)

Revised July 15, 2009

COMPENSATION FOR SERVICES

In consideration of services rendered by the physicians at Active Lifestyles Chiropractic, which may include, but not be limited to, chiropractic care, acupuncture, physical therapy, massage therapy, strength training protocols/programs, or nutritional therapy I recognize that I am responsible for the fees associated with my care.

I understand that my insurance coverage may not cover all my charges and therefore I will be required to cover any gap created. A health insurance policy is an agreement between a policyholder and an insurance company and any disagreement regarding coverage must be determined between the parties. Active Lifestyles Chiropractic is therefore not responsible for settling policy disputes. Our office will be responsible for preparing notes, billing receipts and informal reports as needed to aid in insurance payment/reimbursal.

BENEFITS,RISKS,ALTERNATIVES

There are many approaches to health care. You are here today seeking our expertise in the way we approach health issues and you can be assured that your case will be managed to the best of our ability. The benefits of chiropractic care, acupuncture, physical therapy, massage therapy, strength training, and nutritional therapy are well documented in research. Although there can be great benefits inherent in any of the above modalities, the patient must also be informed that there may be risks involved as well. Those risks, although in our opinion minimal, may manifest themselves in post therapy soreness/stiffness/tenderness, sprains/strains, dislocations, fractures, disc injuries, strokes, allergic reactions. Your alternatives may include; no care, allopathic care, naturopathy, acupuncture, etc. It is impossible for the doctor to foresee every complication or risk that may be possible. You are encouraged to ask your doctor any questions you may have regarding any therapy proposed.

Although the human organism has a biological framework similar from one to the next, each individual is unique. Results may therefore vary. No guarantee of improvement or success can be made.

For females: In the event radiographs are recommended you are advised to inform the doctor and/or radiologist of the date you began your last period _____(date), or if you are pregnant _____(yes)_____(no). INITIALS _____

Witnessed by my signature below, I hereby certify that I am above the age of 18 and or emancipated, and have read the above in its entirety, recognize/agree to its content and hereby **CONSENT FOR TREATMENT** today and all future visits.

My Printed Name _____ My Signature _____

Witnessed By _____ Date _____