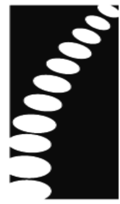

ACTIVE LIFESTYLES
WELLNESS & PERFORMANCE CTR.
chiropractic, physical therapy & nutritional counseling

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 or write us your testimonial. 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, massage and supplement (vitamin)/nutritional therapy. Dr. Res and his staff attend 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.
We strongly recommend you fill out all the forms attached and return them fully completed prior to your appointment. Also, we recommend you provide all imaging (X-Ray, MRI CT scan) reports in your possession relevant to your current complaint.

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.
www.activevero.com, info@activevero.com
Tel No. 772-978-7379, Fax: 772-539-8515

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

Personal History **Custom Foot Orthotics(office total charge $300)- no insurance**

Name: ________________________ Address: ________________________
City: ________________________ State: ______________ Zip Code: ________
Home Phone: ____________________ Birthdate: __________ Age: _____ Sex: M ☐ F ☐
E-Mail: ________________________ Social Security # ______________

Business/Employer (Past work if retired): ____________________ Business Phone: ______________
Address: ____
City: ________________________ State:____Zip Code: ________
Type of Work currently or performed in the past: ______________________________

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

Have you ever worn orthotics before? No____ Yes____. If yes, ____custom-made or ____off the self. How old are they? ____years.
Why are seeking orthotics: Comfort walking____ or comfort running ____?
If you walk or run for exercise, how many miles per week? ____
If you don't walk or run for exercise, are you looking for orthotics for dress/casual shoes? No ____Yes___.

Do your feet currently give you pain? No ____ Yes___. When? __________________
Are you currently receiving treatment for your feet, hips or knees? No___ Yes___
What shoes do you wish your orthotics to fit? Dress____, Walking___, Running___.

Past Health History

Orthopedic Surgeries/Injuries: 1.Feet: ______________ Ankles: ____________________
2. Knees: ________________________________
3. Hips: ________________________________
4. Back: ________________________________

Hospitalization (other than above): ________________________________
____

Medical History

Diabetes: Type_______ **Rheumatoid Arthritis: _________**
Polyneuropathy affecting Feet: _______ **Charcot Foot: _______**

Your Current Weight: ___lbs. **Shoe Size: ___** **Foot Width: Narrow, Medium, Wide**

ACTIVE LIFESTYLES WELLNESS & Performance CTR.

HIPAA Notification Protocol

I, _________________, would like any and all communication with Active Lifestyles Wellness & Performance Center, LLC including, but not limited to, lab test results, diagnostic test results, appointment confirmation, financial account information, missed appointments, to be carried out in accordance with my instructions listed below. I further stipulate that a message may be left on the voicemail ready numbers written below.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Please provide your contact details in the order you wish our office to attempt to contact you:

_____________ Email: ____

_____________ Telephone ____

_____________ Cell Ph: ____

_____________ Business Ph: ____

In the event that any notification attempts made by Active Lifestyles W&P Center are unsuccessful, I grant them permission to have the information verbalized to the following people:

____

____

_________________________________ _____________

Patient Signature **Today's Date**

1715 37th Place, Third Floor

Vero Beach, Florida 32960

Telephone 772-978-7379

Fax 772-539-8515