

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. We also make foot orthotics in this practice to help correct foot misalignments and restore normal pain free foot function. It is a comprehensive type practice and we encourage you to explore all we have to offer.

We strongly recommend you fill out all the forms attached and return them fully completed prior to your appointment. Unlike other offices, we are usually punctual and we therefore ask for your cooperation. Having the paperwork out of the way facilitates this. Also, we recommend you provide us with all imaging (X-Ray, MRI CT scan) reports in your possession relevant to your current complaint or have the office that has them forward it to us. If you are consulting us for nutrition, we ask for all relevant bloodwork results. If you are coming in for massage, realize that a timeframe is reserved for you. If you are late, this will cut into your massage time.

If you have been involved in a motor vehicle accident or in a workman's compensation accident and/or are currently or will be seeking legal help for your difficulties, please let us know prior to scheduling an appointment with us.

We look forward to serving you.

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

Active Lifestyles Wellness and Performance Center, LLC.
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www.activevero.com, info@activevero.com
Ph. No. 772-978-7379, Fax No: 772-539-8515

OFFICE USE Only: BP ___/___ Weight ___ lbs. Pulse ___ bpm Height: ___ Temp: ___
Primary Insurance: _____ Secondary: _____ Co-Pay: \$ _____

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

Personal History

Back and Neck Forms

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

Type of Work performing 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

Current Complaint(s): _____

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:

INITIALLY: No Pain 0 1 2 3 4 5 6 7 8 9 10(excruciating Pain)

NOW (Average): No Pain 0 1 2 3 4 5 6 7 8 9 10(excruciating Pain)

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? _____

Have you had X-rays/ MRIs/ CT scans taken in the last six months? NO. If yes, where? _____

Send us /bring your reports prior to or on the day of your appointment.

How far did you walk/run for exercise prior to the injury? _____miles/day Now? _____miles/day

Do you use assistive devices (canes, walkers, braces, and orthotics)? How long? _____

What is your functional goal in therapy/chiropractic? _____

Past Health History

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia

Other: _____

Orthopedic Surgeries/Injuries: 1.Head:_____Neck:_____

2. Upper Extremity: _____

3. Back: _____

4. Lower Extremity: _____

Previous: Motor Vehicle Accidents: _____ Work Injuries: _____

Hospitalization (other than above): _____

Past Treatment History

Other doctors/ physical, occupational, massage therapists/ acupuncturists, seen **for this current condition?**

Who? _____ Type of Treatment: _____ Results: _____

Who else? _____ Type of Treatment: _____ Results: _____

Chiropractic Care/ Physical Therapy (FOR SIMILAR or OTHER CONDITIONS in the past)

Have you ever had **Chiropractic Care** or **Physical Therapy** (circle one or both if yes)? **NO**

If Yes, **When?** _____ **Where?** _____

For what condition(s)? _____

Results: Excellent Good Fair Poor Chiropractic or Physical Therapy Technique used: _____

Medical Doctor/ Medical Practitioner

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

Insurance Coverage. Please answer the questions below (do not list your insurance coverage here).

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

NOTE: If you are receiving HOME HEALTH services now or in the future while still coming to this office, Medicare will not cover your services here and you will be responsible for all non-covered charges.

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

3. Are you seeking legal counsel or advice for this case? YES/ / NO / /

Past Family History

Please indicate any health issues that are present in your family and that you suffer from too:

Parents: _____

Siblings: _____

Grandparents: _____

Medication and Supplement History

If you will be providing us with a written or typed list, do not complete the table below.

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>When did you start taking</u>

<u>Supplement Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>When did you start taking</u>

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 care.

Check any of the following you have had in the past six months:

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- 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 (cups per day : ___)
- Tea (cups per day: ___)
- Alcohol: ___glasses/week
- Cigarettes: ___/wk., for ___/years
- White Sugar
- Street Drugs: _____

Satisfaction with Diet

- Satisfied
- Somewhat satisfied
- Dissatisfied

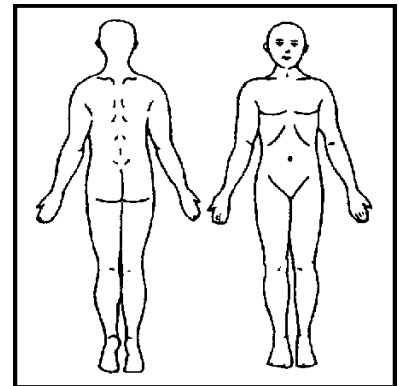
Did you exercise just prior to this injury?

Yes. How many times per wk?

Walk:___ Run:___Swim:___Gym:___

Golf:___ Tennis:___Other:_____

No



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

COMPENSATION FOR SERVICES

In consideration of services rendered by the physicians at Active Lifestyles W & P ctr, 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 W& P ctr 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/reimbursement.

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/ therapist 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 pregnant 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 and/or pregnancy.

Office Policies

We try our best to get you well, but like any good relationship, cooperation and communication is a must. We therefore ask you:

- 1. Respect the appointment time given to you. For cancellations, we expect a call 24 hours ahead of your scheduled appointment for Tuesday through Friday appointments and Friday before 4 pm for Monday appointments. I understand there is a missed appointment fee of \$40 if this is not respected.**
- 2. Follow the recommendations given to you with respect to exercise and activity levels.**
- 3. Communicate all concerns and problems you may encounter with treatment with your therapist/ chiropractor at the next visit.**

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 _____

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