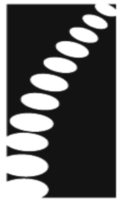


ACTIVE LIFESTYLES
WELLNESS & PERFORMANCE CTR.

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.

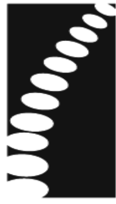
***We strongly recommend** you fill out all the forms attached and return them fully completed prior to your appointment. Unlike other offices, we are usually punctual and we therefore ask for your cooperation. Having the paperwork out of the way facilitates this. Also, we recommend you provide us with 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.
1715 37th Place, Third Floor, Vero Beach Florida, 32960.
www.activevero.com, info@activevero.com
Ph. No. 772-978-7379, Fax No: 772-539-8515



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

Case History Update

Use this form if has been less than 1 year since we last saw you in the office. Otherwise you must complete the other more comprehensive forms.

1. Name:____ Date: ________________________

New address or received a new insurance card since your last visit? Y N (Please provide the office with this information)

2. Current Complaint(s): ____

When did this condition begin? ____________________ Has the condition occurred before? Yes ☐ No ☐

Are you here for balance? Yes No Because of weakness? Yes No Where: ________________________

IF you are NOT seeing us for <u>pain</u> dysfunction please skip to section 4 on the next page.

3. Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: ______________

Date of Injury:______________________________Time of Injury: ____________________________

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: __________________

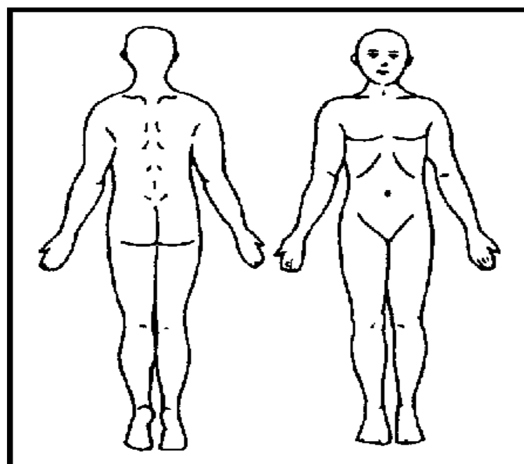
When does it hurt? ☐ Morning ☐ Evening ☐ It wakes me up at night Other: ____________________

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

<u>Place an X on the grade to indicate the severity of your pain:</u>

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)

Indicate where the pain is on the following diagram.



4. 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/swim 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? ________________________________

Indicate where the pain is on the following diagram.

5. Since your last visit with us, what has changed (explain):

a. New Medical Diagnosis: ____

b. Hospitalized: ____

c. New Medications: ____

d. New Supplementation: ____

e. New job: ____

f. New social environment: ____

g. New Level of activity:____

h. New Assistive Devices(walker, cane, orthotics, braces):___________________________

6. Who else have you seen for this problem prior to seeing us? ____ Nobody ____ My medical doctor who refers me.

a.____________________ Result:______________________________________

b.____________________ Result:______________________________________

c.____________________ Result:______________________________________

Signature: _______________________________ Date: __________________________

OFFICE USE Only: BP____/_____ Weight_____lbs. Pulse___bpm Height: _____ Temp: ___________

Primary Insurance: _______________Secondary:_________________ Co-Pay:$____________

Last Office Visit: ___________________________ Case: ______________________________

Total number of visits: ________________________

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