

# Welcome to

# ACTIVE CHIROPRACTIC

Name: \_\_\_\_\_ Age: \_\_\_ Date: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_  
 Email: \_\_\_\_\_ Single: \_\_\_ Married: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_  
 Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Emergency Contact/Number: \_\_\_\_\_

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## YOUR HEALTH PROFILE

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

### Your Childhood Years (birth to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure		Yes	No	Unsure
Did you have any childhood illnesses?				Was there any prolonged use of medicine such as antibiotics or an inhaler?			
Did you have any serious falls as a child?				Did you suffer any other traumas (physical or emotional)?			
Did you play youth sports?				Were you vaccinated?			
Did you have any surgery?				As a child, were you under regular Chiropractic care?			
Did you fall from over 3 feet (crib, bed, tree)?							
Were you involved in any car accidents as a child?							

Comments: \_\_\_\_\_

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### Adult (18 to present)

	Yes	No		Yes	No
Do / did you smoke?			Do / did you play any adult sports?		
Do / did you drink alcohol?			Do / did you participate in extreme sports?		
Have you been in any accidents?			On a scale of 1 – 10 describe your stress level: (1 = none / 10 = Extreme)		
Have you had any surgery?			Occupational _____		
			Personal _____		

Comments (explain if yes above): \_\_\_\_\_

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On a scale of Poor, Good, Excellent describe your:  
 Diet \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_

Have you ever:

Bought bottled water:	YES	NO
Belonged to a health club:	YES	NO
Consumed vitamins or supplements:	YES	NO

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## Addressing The Issues That Brought You To Our Office

If you have no symptoms or complaints, and are here for wellness services, please check here  **“Wish to have Chiropractic Wellness Services”** and skip to **“Family Health Profile.”** Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

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If you are experiencing pain, is it...

Sharp

Dull

Comes and goes

Travels

Constant

Since the problem started, it is...

About the same

Getting better

Getting worse

What makes it worse: \_\_\_\_\_

Yes, it interferes with:

Work

Sleep Walking

Sitting

Hobbies

Leisure

Other Doctors seen for this problem (please list)

Chiropractor (have you ever been, problem) \_\_\_\_\_

Medical Doctor \_\_\_\_\_

Other \_\_\_\_\_

Please check all symptoms you **have ever had**, even if they do not seem related to your current problem.

Headaches

Pins and needles in legs

Fainting

Neck pain

Pins and needles in arms

Loss of smell

Back pain

Loss of Balance

Dizziness

Buzzing in Ears

ringing in Ears

Nervousness

Numbness in fingers

Numbness in toes

Loss of taste

Stomach Upset

Fatigue

Depression

Irritability

Tension

Sleeping problems

Neck stiff

Cold hands

Cold feet

Diarrhea

Constipation

Fever

Hot flashes

Cold sweats

Lights bother eyes

Problem Urinating

Heartburn

Mood swings

Menstrual pain

Menstrual irregularity

Ulcers

List any medications you are taking \_\_\_\_\_

What is your Health Philosophy? (What should you do to be healthy?)

How do you want us to handle your condition/problem?

Temporary Correction (correct symptoms)

Maximum Restoration (correct cause of symptoms)

What are your expectations of us? \_\_\_\_\_

### Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children \_\_\_\_\_

Spouse \_\_\_\_\_

Mother \_\_\_\_\_

Father \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

Others \_\_\_\_\_

*The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.*

\_\_\_\_\_  
*Signature / Date*

## Active Chiropractic Financial Agreement

Dear Patient:

Active Chiropractic will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Active Chiropractic.

We wish to make it very clear that your health is your sole responsibility.

These policies apply only to the services actually preformed, and in no way obligates the patient to continue the course of care recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I choose the following method of payment for my care at Active Chiropractic:

\_\_\_\_\_ **CASH** - Payment is due at the time of services. All patients who wish to file their own insurance may receive the same cash price by paying for the service at the time of the service and waiting for reimbursement from their insurance company.

\_\_\_\_\_ **MEDICARE** - Payment is due at time of service.

\_\_\_\_\_ **WORKERS COMPENSATION** - My employer has agreed to pay for the services rendered by Active Chiropractic. I understand that I am responsible for any portion of this bill that my employer or his insurance carriers may refuse to pay.

\_\_\_\_\_ **PERSONAL INJURY** - Although my insurance or lawsuit may eventually pay Active Chiropractic in full for services rendered, I agree to pay Active Chiropractic \$100 towards my initial visit, and \$50 per week there after, until my bill is paid in full, whether active or inactive. Should insurance or lawsuit pay in full, all monies I have paid to Active Chiropractic will be refunded to me in full. Should insurance or lawsuit only pay a portion of services billed, balance overages will be refunded to me and I agree to pay for any and all remaining services.

\_\_\_\_\_ **INSURANCE POLICY COVERAGE** - Although I am totally responsible for charges I may incur at Active Chiropractic, I will initially pay for my yearly deductible and the percentage agreed upon at the time of each visit unless my insurance fails to pay it's share, at which time I will pay my balance in full.

\_\_\_\_\_ **CARE CREDIT** – Upon approval from care credit I will pay for each visit using the care credit card or in advance for a series of treatments.

NOTE: Active Chiropractic will refund or apply to future services any overpayments made by patient at patients option.

PATIENTS NAME: *(please print)* \_\_\_\_\_

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*Signature/Date*

## Insurance Agreement

**ACTIVE CHIROPRACTIC**  
**1521 E BOISE AVE**  
**BOISE, ID 83706**  
**(208)345-3320**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Employer \_\_\_\_\_

Enrollee ID # \_\_\_\_\_

Group# \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Insured's Relation to Patient \_\_\_\_\_

Insured's Address (if different then patient's) \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check made out and mailed to **Active Chiropractic**. If my current policy prohibits direct payment to Active Chiropractic, I hereby also instruct and direct you to make out the check to me and mail it to the address above for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **This is a direct assignment of my rights and benefits under this policy.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.

I authorize Active Chiropractic to initiate a complaint to the insurance Commissioner for any reason on my behalf.

\_\_\_\_\_  
**Signature of policy holder**

\_\_\_\_\_  
**Signature of claimant, other than policy holder**

\_\_\_\_\_  
**Witness**

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

## Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

### We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

### We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

### You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential Communications
- Amend your protected health information

**These privacy practices are effective: 10/01/2006**

**For further information please contact: Office Manager**

## Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

## Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

## Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

\_\_\_\_\_

*patient or guardian signature*

\_\_\_\_\_

*date*