ALIVE Chiropractic & Rehabilitation

**PATIENT INFORMATION**

**Name:** (First)_____(MI)_____(Last)_____ Preferred name: _____

**Birth Date** (MM/DD/YYYY) _____ **Age:** _____ **Gender:** M / F / X **SSN**: _____

**Address:** _____ (City) _____ (State)_____ (Zip) _____

**Phone:** (_____) - _____ **Email**: _____

**Occupation**: _____ **Employer:** _____

**Emergency Contact**: Name: _____ Relationship: _____ Phone: (_____) -_____

**How did you find out about Alive Chiropractic & Rehabilitation?**

- ☐ Referral (please provide a name so we can thank them!) _____
- ☐ Internet (please circle): Google Facebook Instagram Twitter Other: _____
- ☐ Office street signage
- ☐ Other: _____

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**Parent/Guardian (If patient is under age 18):**

Name: _____ Relationship to patient: _____ Phone Number: (_____) _____

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**HEALTH INFORMATION**

**Chief Complaint:**

| List your current health concern(s) | How long have you had this condition? |
|---|---|
| | |
| | |
| | |

**Using the appropriate symbol, mark the area(s) on your body where you feel any of the following sensations**

**Aching** XXXXXX

**Stabbing** ϕϕϕϕϕϕ

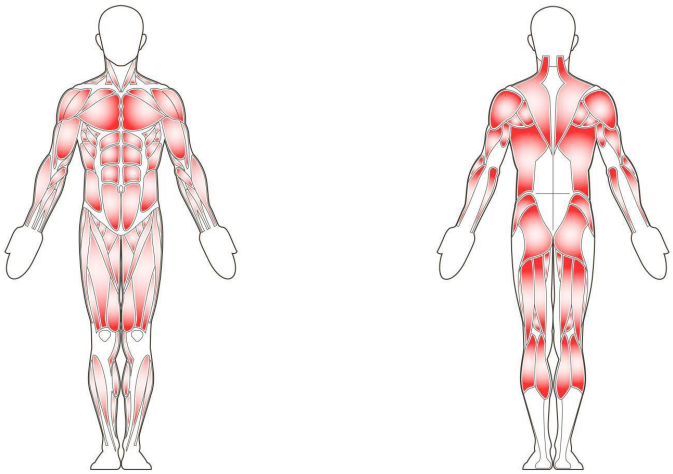
**Numbness** oooooooo

**Tingling** ----------

**Burning** ^^^^^^^

**Cramping** ∞∞∞∞∞

**Electrical** ↓↓↓↓↓↓



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**MEDICAL HISTORY**

Please select or list any illnesses that you have ever had. Check all that apply.

- ☐ Angina
- ☐ Arthritis
- ☐ Cancer
- ☐ Clotting disorder
- ☐ COPD
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Nerve or muscle disease
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Stroke
- ☐ Ulcer
- ☐ Other _____
- ☐ Other _____

Please circle the following option that applies to you and answer the questions to the best of your ability.

| | | | |
|---|---|---|---|
| Past Injuries | No | Yes | Please list: |
| Hospitalizations | No | Yes | Please list: |
| Surgeries | No | Yes | Please list: |

Please list any major health conditions that run in your family.

| **Family Member** | **Health Condition(s)** |
|---|---|
| | |
| | |
| | |

**Height**: _____**Weight:** _____lbs

| | | | | | |
|---|---|---|---|---|---|
| Exercise | No | Yes | Type: | Frequency: | Duration: |
| Tobacco | No | Yes | Type: | How much? | |
| Have you ever smoked? | No | Yes | Start year: | End year: | |
| Allergies | No | Yes | Please list: | | |
| Medications | No | Yes | Please list: | | |
| Vitamins/Supplements | No | Yes | Please list: | | |

**REVIEW OF SYSTEMS:** Please select any symptoms or conditions that you ***currently*** have:

**Constitutional:**
- ☐ Sudden weight loss
- ☐ Fatigue
- ☐ Poor appetite
- ☐ Fever
- ☐ Weakness
- ☐ Fainting

**Cardiovascular:**
- ☐ Chest pain
- ☐ Palpitations
- ☐ Leg cramping
- ☐ Swelling
- ☐ Bruising

**Respiratory:**
- ☐ Coughing
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Shortness of breath

**Gastrointestinal:**
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Indigestion
- ☐ Bloating
- ☐ Cramping
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation

**Genitourinary:**
- ☐ Problems with urination
- ☐ Vaginal discharge or pain
- ☐ Increased/decreased menses

**Musculoskeletal:**
- ☐ Neck pain
- ☐ Back pain
- ☐ Hip issues
- ☐ Knee issues
- ☐ Foot/ankle issues
- ☐ Shoulder issues
- ☐ Elbow/wrist /hand issues
- ☐ TMJ/Jaw issues
- ☐ Headaches

**Integumentary/Skin:**
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rashes
- ☐ Itching
- ☐ Hair loss

**Neurological**
- ☐ Dizziness
- ☐ Pins and needles
- ☐ Numbness
- ☐ Blurred vision
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Speech problems
- ☐ Memory problems
- ☐ Balance problems

**Psychiatric**
- ☐ Anxiety
- ☐ Depression

**Endocrine/Immune**
- ☐ Thyroid issues
- ☐ Blood sugar issues
- ☐ PMS symptoms
- ☐ Immune disorders
- ☐ Frequent infections
- ☐ Swollen glands

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**Protected Health Information**

I certify that I am the patient or legal guardian listed above and certify the information provided to be true and accurate to the best of my knowledge. I consent to the collection and use of my protected health information by Alive Chiropractic & Rehabilitation for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for general healthcare operations. I hereby authorize Alive Chiropractic & Rehabilitation to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement or charges incurred by me.

I understand I have a right to review Alive Chiropractic & Rehabilitation's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and Alive Chiropractic & Rehabilitation's duties regarding the types of uses and disclosures of my Protected Health Information.

**Informed Consent to Chiropractic Treatment**

I hereby request and consent to the performance of chiropractic adjustments and procedures including various modes of physical therapy, manual therapy and therapeutic exercise by the chiropractic physician. I understand I can at any time ask questions and discuss with the physician the nature and purpose of any procedure. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, chiropractic treatment carries some risks, including, but not limited to: fractures, disc injuries, dislocations, strains and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications.

**Financial & Cancellation Policy**

To serve your financial needs, our office offers several methods of payment:

- Cash/Check/Credit Card: Fees must be paid at the time services are rendered. A time of service discount will be applied to all fees paid in full at the time of service for accounts not requiring insurance billing.
- Private/Auto/Worker's Compensation Insurance: We offer direct billing as a courtesy to our patients. Your insurance benefits are an agreement between you and your insurance company. There is no guarantee your insurance will cover the cost of treatment. You are liable for any charges incurred that are not covered by your insurance company, including deductibles, copays and coinsurances.

I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Alive Chiropractic & Rehabilitation.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

I hereby assign all chiropractic benefits, and all other major medical benefits to which I am entitled (Medicare, private insurance, and all other health plans) to: Alive Chiropractic & Rehabilitation.

**Cancellation Policy**

Appointments can be re-scheduled or cancelled if we are notified 12 hours before your scheduled appointment. Cancellations or missed appointments may be subject to a cancellation fee up to $100 if the 12 hour notice was not given.

I affirm that I understand and agree to the above statements of authorization and the financial and cancellation policy. I intend this consent form to cover my present condition(s) and for any future condition(s) for which I seek treatment at this facility.

_____ _____

Signature of Patient or Personal Representative Date