Active Spine Chiropractic

570 Williamson Road
Mooresville, NC 28117
704-663-7625 • ActiveSpineNC.com

Welcome

The doctors and staff of Active Spine Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Insurance

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Patient Identification

-PLEASE PRINT-

_____ _____ _____
Last Name *First Name (Legal)* *Preferred to be Called*

_____/_____/_____ ❒ *Male* ❒ *Female* _____-_____-_____ ❒ *Married* ❒ *Single* ❒ *Widowed*
Birthdate *Social Security Number*

_____ ❒ *Full-Time* ❒ *Part-Time* ❒ *Not Employed* ❒ *Self-Employed* ❒ *Retired* ❒ *Active Military*
Employer/School

_____/_____-_____ _____/_____-_____ _____/_____-_____
Home Phone *Work Phone* *Cell Phone*

_____
Address

_____ _____ _____
City *State* *Zip*

_____ _____/_____-_____
Emergency Contact *Phone Number*

_____
Email Address
(We only use your email for contact, newsletters and updates about our practice. We do not share emails with or sell to any third-party.)

Acceptance As Patient

I understand and agree that the doctors of Active Spine Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

_____ _____
Signature *Date*

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Patient Name _____ *Date* _____

Do you have vertigo (dizziness)?	❒ Yes	❒ No
Do you pass out easily (faint or loss of consciousness)?	❒ ***Yes***	❒ ***No***
Do you have double vision or have you lost sight in one eye?	❒ Yes	❒ No
Do you have any slurred speech or difficulty with speech?	❒ ***Yes***	❒ ***No***
Do you have indigestion or difficulty swallowing?	❒ Yes	❒ No
Do you have any difficulty walking, with coordination or falling to one side?	❒ ***Yes***	❒ ***No***
Do you have nausea or vomiting?	❒ Yes	❒ No
Do you have numbness on one side of your face or body?	❒ ***Yes***	❒ ***No***
Do you have any visual disturbances or rapid eye movement?	❒ Yes	❒ No
Do you have or have you ever had difficulty in arranging words properly?	❒ ***Yes***	❒ ***No***
Do you have a headache or head pain that is unlike any you have had before?	❒ Yes	❒ No
Do you have headaches for hours or days?	❒ ***Yes***	❒ ***No***
Do you have chest pain?	❒ Yes	❒ No
Do you have difficulty breathing?	❒ ***Yes***	❒ ***No***
Do you have any change in bowel or bladder habits?	❒ Yes	❒ No
Do you have a sore that does not heal?	❒ ***Yes***	❒ ***No***
Do you have any unusual bleeding or discharge?	❒ Yes	❒ No
Do you have any thickening in your breasts or elsewhere?	❒ ***Yes***	❒ ***No***
Do you have a change in any wart or mole?	❒ Yes	❒ No
Do you have a nagging cough or hoarseness?	❒ ***Yes***	❒ ***No***
Do you have night sweats?	❒ Yes	❒ No
Do you have pain in neck, jaw or face?	❒ ***Yes***	❒ ***No***
Do you have a drooping eyelid or change in your pupils?	❒ Yes	❒ No
Do you have any ringing in your ears?	❒ ***Yes***	❒ ***No***
Does your pain ever wake you from a sound sleep?	❒ Yes	❒ No
Are you losing or gaining weight now without trying?	❒ ***Yes***	❒ ***No***
Are you coughing up blood or noticing it in your stools or urine?	❒ Yes	❒ No
Have you had any loss of bladder or bowel control?	❒ ***Yes***	❒ ***No***
Have you lost consciousness or had double vision recently?	❒ Yes	❒ No
Are you seeing any other doctor now for any reason?	❒ ***Yes***	❒ ***No***
Have you felt fatigued or weak for no apparent reason?	❒ Yes	❒ No
Has there recently been a change in your appetite?	❒ ***Yes***	❒ ***No***
Have you had a recent fever or chills?	❒ Yes	❒ No

Additional Comments: _____

_____

_____

Patient Signature _____ *Date* _____

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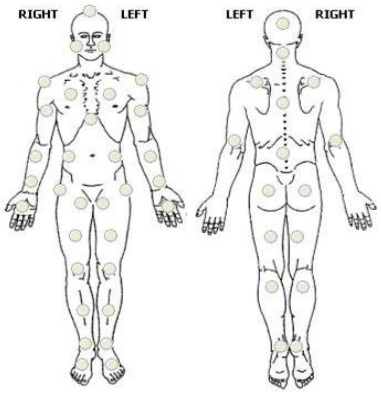
Complaint : _____

Circle the area where you have PAIN:



Pain Came On: ❒ Gradually ❒ Immediately
Pain Is Getting: ❒ Better ❒ Same ❒ Worse

Grade: _____ *(On A Scale Of 1-10, 1=good 10=bad)*

Intensity: ❒ Minimal ❒ Slight ❒ Moderate ❒ Severe
Frequency: ❒ Intermittent ❒ Occasional ❒ Frequent ❒ Constant

Describe Feeling: ❒ Dull ❒ Sharp ❒ Aching ❒ Shooting ❒ Spasm ❒ Throbbing ❒ Burning ❒ Numbing ❒ Tingling ❒ Other:_____

How Long Has It Been Hurting: _____
How Did You Get This Injury: _____

Please check mark the Actions Affecting this Pain: (B) Brings On (A) Aggravates (R) Relieves

In the Morning:	❒ B	❒ A	❒ R	In the Afternoon:	❒ B	❒ A	❒ R	Bending Forward:	❒ B	❒ A	❒ R
Bending Back:	❒ B	❒ A	❒ R	Bending Left:	❒ B	❒ A	❒ R	Bending Right:	❒ B	❒ A	❒ R
Twisting Left:	❒ B	❒ A	❒ R	Twisting Right:	❒ B	❒ A	❒ R	Coughing:	❒ B	❒ A	❒ R
Sneezing:	❒ B	❒ A	❒ R	Straining:	❒ B	❒ A	❒ R	Standing:	❒ B	❒ A	❒ R
Lifting:	❒ B	❒ A	❒ R	Sitting:	❒ B	❒ A	❒ R	Heat:	❒ B	❒ A	❒ R
Cold:	❒ B	❒ A	❒ R	Rest:	❒ B	❒ A	❒ R	Lying Down:	❒ B	❒ A	❒ R
Medications:	❒ B	❒ A	❒ R								

❒ **Nothing Relieves the Pain** Other : _____ ❒ B ❒ A ❒ R

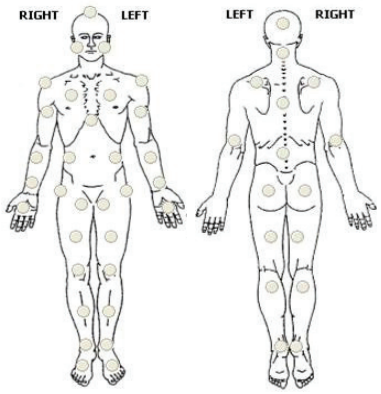
Pain Radiates To:

Head:	❒ Right	❒ Left		Neck:	❒ Right	❒ Left		Shoulder:	❒ Right	❒ Left	
Arm:	❒ Right	❒ Left		Hand:	❒ Right	❒ Left		Hip:	❒ Right	❒ Left	
Leg:	❒ Right	❒ Left		Foot:	❒ Right	❒ Left					

Pain Also Radiates To: _____

Complaint : _____

Circle the area where you have PAIN:



Pain Came On: ❒ Gradually ❒ Immediately
Pain Is Getting: ❒ Better ❒ Same ❒ Worse

Grade: _____ *(On A Scale Of 1-10, 1=good 10=bad)*

Intensity: ❒ Minimal ❒ Slight ❒ Moderate ❒ Severe
Frequency: ❒ Intermittent ❒ Occasional ❒ Frequent ❒ Constant

Describe Feeling: ❒ Dull ❒ Sharp ❒ Aching ❒ Shooting ❒ Spasm ❒ Throbbing ❒ Burning ❒ Numbing ❒ Tingling ❒ Other:_____

How Long Has It Been Hurting: _____
How Did You Get This Injury: _____

Please check mark the Actions Affecting this Pain: (B) Brings On (A) Aggravates (R) Relieves

In the Morning:	❒ B	❒ A	❒	In the Afternoon:	❒ B	❒ A	❒ R	Bending Forward:	❒ B	❒ A	❒ R
Bending Back:	❒ B	❒ A	❒ R	Bending Left:	❒ B	❒ A	❒ R	Bending Right:	❒ B	❒ A	❒ R
Twisting Left:	❒ B	❒ A	❒ R	Twisting Right:	❒ B	❒ A	❒ R	Coughing:	❒ B	❒ A	❒ R
Sneezing:	❒ B	❒ A	❒ R	Straining:	❒ B	❒ A	❒ R	Standing:	❒ B	❒ A	❒ R
Lifting:	❒ B	❒ A	❒ R	Sitting:	❒ B	❒ A	❒ R	Heat:	❒ B	❒ A	❒ R
Cold:	❒ B	❒ A	❒ R	Rest:	❒ B	❒ A	❒ R	Lying Down:	❒ B	❒ A	❒ R
Medications:	❒ B	❒ A	❒ R								

❒ **Nothing Relieves the Pain** Other : _____ ❒ B ❒ A ❒ R

Pain Radiates To:

Head:	❒ Right	❒ Left		Neck:	❒ Right	❒ Left		Shoulder:	❒ Right	❒ Left	
Arm:	❒ Right	❒ Left		Hand:	❒ Right	❒ Left		Hip:	❒ Right	❒ Left	
Leg:	❒ Right	❒ Left		Foot:	❒ Right	❒ Left					

Pain Also Radiates To: _____

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The Complaints are Getting: ❒ Better ❒ Same ❒ Worse

Can You Go To Sleep Without Problems? ❒ Yes ❒ No

Have You Lost Time From Work? ❒ Yes ❒ No

Do You Awaken Because Of Pain? ❒ Yes ❒ No

If Yes, For How Long? _____

If Yes, Where? _____

Can You Do Physical Work Activities? ❒ Yes ❒ No

Have You Had Sleep Problems Before? ❒ Yes ❒ No

If No, Why? ❒ Pain ❒ Weakness ❒ Stress ❒ Other

The Patient is Having Problems With:

❒ Seeing	❒ Tasting	❒ Smelling	❒ Eating	❒ Nervous	❒ Tactile Feeling
❒ Hearing	❒ Bathing	❒ Grooming	❒ Dressing	❒ Irritable	❒ Loss of Concentration
❒ Reading	❒ Typing	❒ Writing	❒ Grasping	❒ Sports	❒ Change in Personality
❒ Holding	❒ Pinching	❒ Standing	❒ Leaning	❒ Reclining	❒ Restful Sleeping
❒ Walking	❒ Stooping	❒ Squatting	❒ Climbing	❒ Insomnia	❒ Loss of Sexual Drive
❒ Kneeling	❒ Bending	❒ Twisting	❒ Carrying	❒ Exercising	❒ Using the Toilet
❒ Lifting	❒ Pushing	❒ Pulling	❒ Reaching		
❒ Sitting	❒ Driving	❒ Riding Car	❒ Plane Travel		

Please list your Past Medical Conditions *(i.e. Heart Disease, High Cholesterol, Cancer, etc.)*

_____

_____

Please list Medical Conditions of Family Members *(i.e. Heart Disease, High Cholesterol, Cancer, etc. : (Heart Disease - Mother's Father))*

_____

_____

Please list any Past Surgical Procedures with dates *(i.e. Knee Surgery, Heart Surgery, etc.)*

_____

_____

Please list the Medications, Vitamins, and Nutritional Supplements that you are currently taking.

_____

_____

Please list any Allergies you may have *(i.e. Sulfur, Penicillin, Pets, Seafood, etc.)*

_____

_____

Please check one: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated

Do you use any of the following: ❒ Tobacco ❒ Alcohol ❒ Coffee How many Children do you have? _____

_____ _____

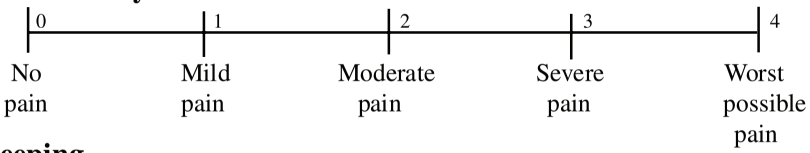
Patient Signature ***Date***

Functional Rating Index

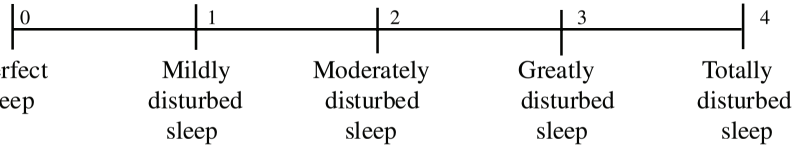
- FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY -

In order to properly assess your condition, we must understand how much ***your neck and/or back problems*** have affected your ability to manage everyday activities. For each item below, ***please circle the number which most closely describes your condition right now.***

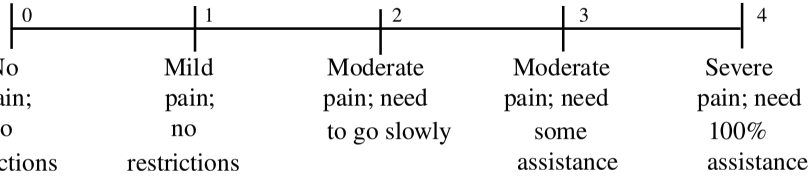
1. Pain Intensity



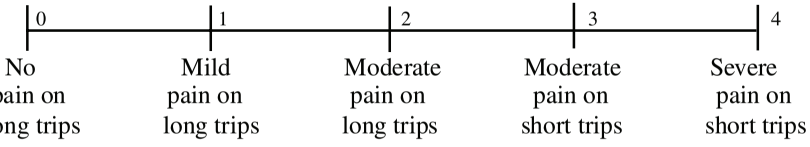
2. Sleeping



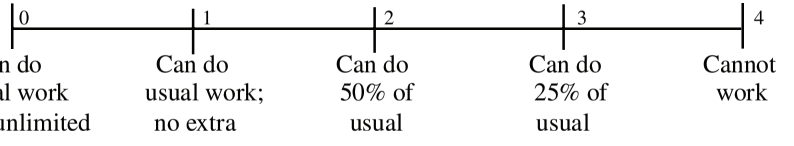
3. Personal Care (washing, dressing, etc.)



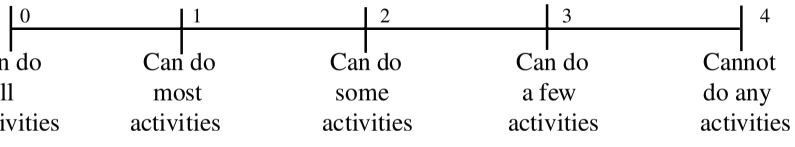
4. Travel (driving, etc.)



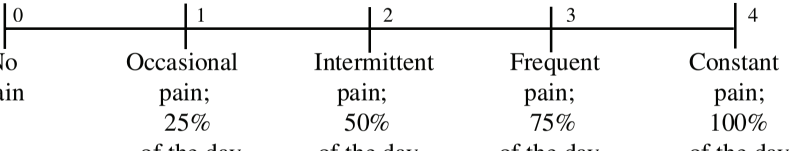
5. Work



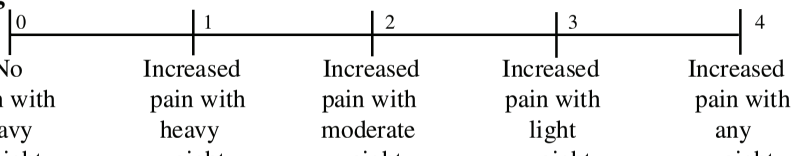
6. Recreation



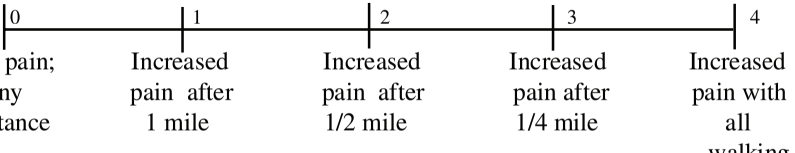
7. Frequency of pain



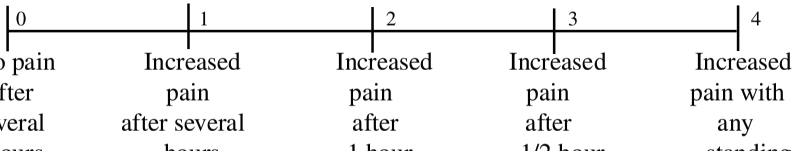
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

_____

Signature

_____

Date

Total Score _____

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Assignment of Insurance Benefits

_____ _____/_____/_____

Patient's Name *Patient's Date of Birth*

_____ _____/_____/_____

Insured's Name *Insured's Date of Birth*

I authorize and direct that payment be made directly to:

Active Spine Chiropractic, 570 Williamson Road, Mooresville, NC 28117

For any and all insurance benefits or reimbursement for services rendered by Active Spine Chiropractic which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

Release of Information

By signing below, I authorize the release of any information concerning my health and health care services to my insurance companies, other health care professionals, or hospitals when necessary for diagnosis, assessment, or treatment of my health condition. I also authorize the release of any health information and billing records to another party if they are potentially responsible for payment of my services.

Payment Agreement

I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Consent To Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me *(or on the patient named below, for whom I am legally responsible)* by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

HIPPA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review this Chiropractic Offices's Notice of HIPPA Privacy Practices for protected health information.

_____ _____

Patient Signature *Date*

_____ _____

Witness Signature *Date*