



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

_____/_____/_____
Birthdate

Male Female

_____-_____-_____
Social Security Number

Married Single Widowed

 Employer School

Full-Time Part-Time Not Employed
 Self-Employed Retired Active Military

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

Additional Comments: _____

Patient Signature _____

Date _____



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Complaint : _____

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

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

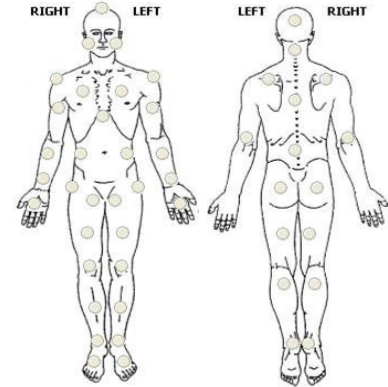
Intensity: Minimal Slight Moderate Severe
Frequency: Intermittent Occasional Frequent Constant

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

How Long Has It Been Hurting: _____

How Did You Get This Injury: _____

Circle the area where you have PAIN:



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

In the Morning: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	In the Afternoon: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Forward: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Bending Back: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Twisting Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Twisting Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Coughing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Sneezing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Straining: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Standing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Lifting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Sitting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Heat: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Cold: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Rest: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Lying Down: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Medications: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R		

Nothing Relieves the Pain Other : _____ B A R

Pain Radiates To:

Head: <input type="checkbox"/> Right <input type="checkbox"/> Left	Neck: <input type="checkbox"/> Right <input type="checkbox"/> Left	Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left
Arm: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left
Leg: <input type="checkbox"/> Right <input type="checkbox"/> Left	Foot: <input type="checkbox"/> Right <input type="checkbox"/> Left	

Pain Also Radiates To: _____

Complaint : _____

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

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

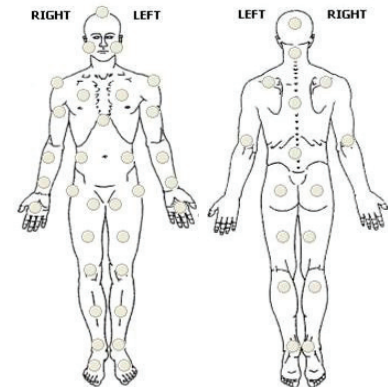
Intensity: Minimal Slight Moderate Severe
Frequency: Intermittent Occasional Frequent Constant

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

How Long Has It Been Hurting: _____

How Did You Get This Injury: _____

Circle the area where you have PAIN:



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

In the Morning: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	In the Afternoon: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Forward: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Bending Back: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Twisting Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Twisting Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Coughing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Sneezing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Straining: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Standing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Lifting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Sitting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Heat: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Cold: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Rest: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Lying Down: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Medications: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R		

Nothing Relieves the Pain Other : _____ B A R

Pain Radiates To:

Head: <input type="checkbox"/> Right <input type="checkbox"/> Left	Neck: <input type="checkbox"/> Right <input type="checkbox"/> Left	Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left
Arm: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left
Leg: <input type="checkbox"/> Right <input type="checkbox"/> Left	Foot: <input type="checkbox"/> Right <input type="checkbox"/> 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:

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

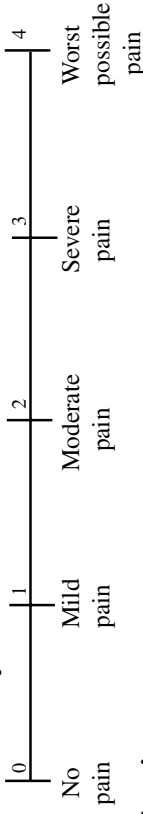
Date

Functional Rating Index

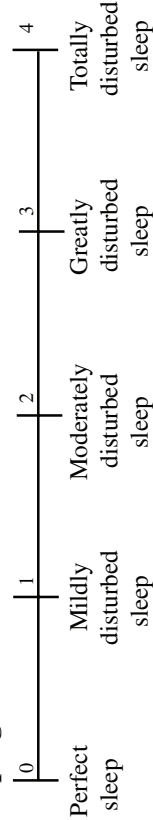
- FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY -

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.*

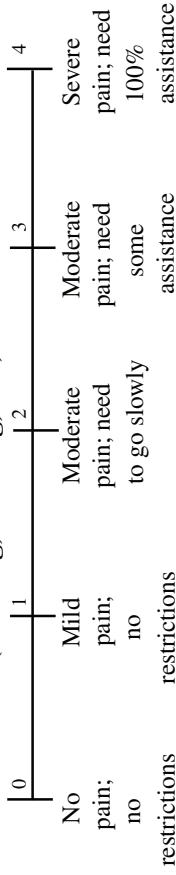
1. Pain Intensity



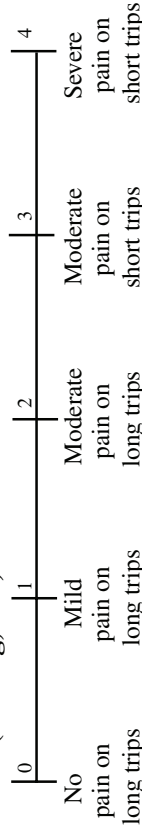
2. Sleeping



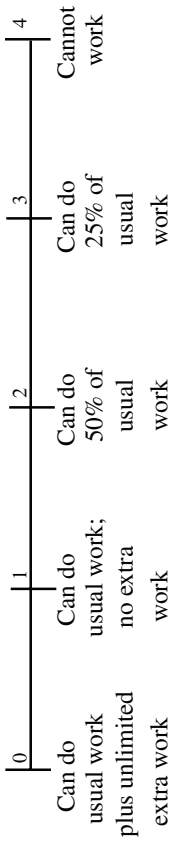
3. Personal Care (washing, dressing, etc.)



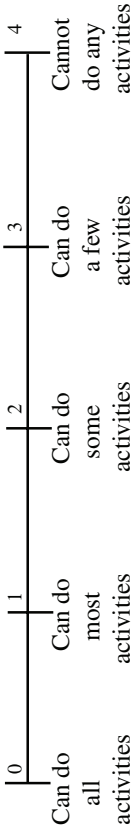
4. Travel (driving, etc.)



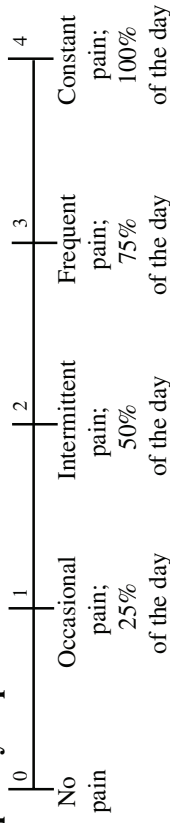
5. Work



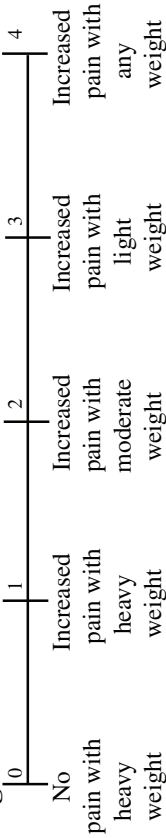
6. Recreation



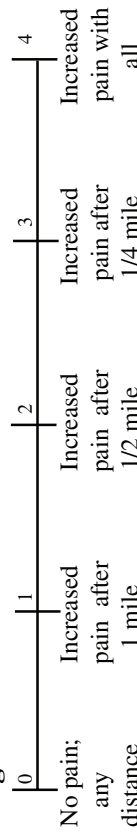
7. Frequency of pain



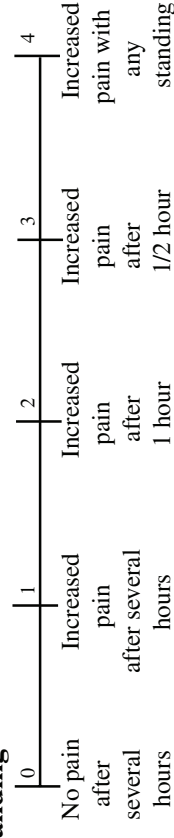
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature _____

Total Score _____

Date _____



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Assignment of Insurance Benefits

Patient's Name

_____/_____/_____
Patient's Date of Birth

Insured's Name

_____/_____/_____
Insured's Date of Birth

Insured's Address (if different from Patient)

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. I also understand that if my account becomes delinquent, Active Spine Chiropractic will utilize the services of a collection agency. If this action is needed, I will be responsible for any additional fees accumulated to collect my outstanding balance.

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