ACTIVE LIFESTYLE MEDICAL/CHIROPRACTIC HEALTH & WELLNESS CENTER

LAST NAME: **FIRST NAME:** **MIDDLE INITIAL:**

NICK NAME: **BIRTHDATE:** **AGE:** **TODAY'S DATE:**

Patient Information

Address _____

City _____ State _____ ZIP _____

Home Phone (___)_____ Cell Phone (___)_____

Email Address _____

SS# _____ Sex ☐M ☐F

Occupation _____

Employer _____

Work Phone (___)_____ Extension _____

□Married □Widowed □Single □ Minor
□Separated □Divorced □Partnered for _____ years

IN CASE OF EMERGENCY

Name _____ Relationship _____

Home Phone (___)_____ Cell Phone (___)_____

Which of the following of our marketing have you seen?

☐ Direct mail ☐ Friend: _____
☐ Internet ☐ Magazine(Which One _____)
☐ Radio ☐ Talk:_____
☐ Sign ☐ Other:_____

What specifically prompted you to choose us for your healthcare needs? _____

_____

Name of Primary Care Provider:

_____

City, State: _____

Last check up: _____

Are you under a doctor's care at the present time? ☐Yes ☐No

If yes, for what? _____

Name of Doctor: _____

City, State: _____

Insurance Information

Primary Subscriber _____

Relationship to Patient_____

Insurance Co. _____

ID # _____

Is there a Secondary Insurance? ☐Yes ☐No

Insurance Co. _____

ID # _____

ASSIGNMENT AND RELEASE

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay ALM/CHWC the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of any health insurance or medical plan benefits directly to ALM/CHWC for medical services rendered and for any supplies, tests, or medications provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other legal remedies necessary in connection with same. I hereby assign directly to ALM/CHWC all current and prior rights, if any, to payment and benefits and all legal and other health plan rights that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This assignment includes, but is not limited to, a designation that ALM/CHWC personnel can act on my / our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to ALM/CHWC as a result of services rendered by ALM/CHWC and authority to pursue any and all remedies to which I / we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

FINANCIAL POLICY

We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Mastercard and Care Credit. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Rep.

_____ _____
Date Relationship to Patient

ACTIVE LIFESTYLE MEDICAL/CHIROPRACTIC HEALTH & WELLNESS CENTER

LAST NAME: **FIRST NAME:** **MIDDLE INITIAL:**

NICK NAME: **BIRTHDATE:** **AGE:** **TODAY'S DATE:**

Medical History

Gynecologic History

Are you currently pregnant? ☐Yes ☐No
Pregnancies #:_____ Dates: _____
Deliveries #_____ Natural delivery or C-section? _____
Menstrual: Onset:_____ Duration: _____
Are they regular? ☐Yes ☐No
Pain associated? ☐Yes ☐No
Last menstrual period: _____

General History (Check all that apply to you)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Transfusion
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chest pain
- ☐ Chicken Pox
- ☐ Cholera
- ☐ Constipation
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Gallbladder Disorder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hormone Replacement Therapy
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Malaria
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nervous Breakdown
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ STD
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Swelling feet
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Whooping Cough
- ☐ Other: _____ _____

Medications

Medications:	***Dosages:***
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Use back of sheet if additional space is needed.)

Birth Control: _____

Medication Allergies:	***General Allergies:***
_____	_____
_____	_____
_____	_____

Do you have any surgical devices in your body? *(i.e. screws, pins, plates, etc?*
If yes, where are they located?_____

ACTIVITY LEVEL

Select one of the following:

☐ Inactive: no regular physical activity with a sit-down job

☐ Light Activity: no organized physical activity during leisure time

☐ Moderate Activity: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

☐ Heavy Activity: consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week.

☐ Vigorous Activity: participation in extensive physical exercise for at least 60 minutes per session, 4 or more times per week.

Family History

Possible Hereditary Diseases:_____

_____

_____

Social Habits

***Habits*:** (please select all that apply)

□ Smoking	Packs/day: _____
□ Alcohol	Drinks/week: _____
□ Coffee/Caffeine drinks	Cups/day: _____
□ High Stress level	Reason: _____

ACTIVE LIFESTYLE MEDICAL/CHIROPRACTIC HEALTH & WELLNESS CENTER

LAST NAME: **FIRST NAME:** **MIDDLE INITIAL:**

NICK NAME: **BIRTHDATE:** **AGE:** **TODAY'S DATE:**

Surgical History

Past Surgical History_____

_____

_____

_____

_____

_____

_____

_____

_____

Nutrition

Present Height: _____ feet _____ inches

Present Weight: _____ lbs.

Ideal Weight: _____lbs.

Weight at age 20: _____lbs.

Do you eat/snack after your evening meal? ☐YES ☐ NO

If yes, what and how much do you eat? _____

_____

What beverages do you drink throughout a day? _____

_____

PHYSICAL MEDICINE CURRENT CONDITIONS

Reason for Visit?_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ☐Yes ☐No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting

□Burning □Tingling □Cramps □Stiffness □Swelling □Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your □Work □Sleep □Daily Routine □Recreation

Indicate activities which are painful to perform: □ Sitting □ Standing □ Walking □ Bending □Lying Down

What treatment have you already received for your condition? □ Medication □ Surgery □ Physical Therapy

□ Chiropractic Services □ None □ Other_____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of Last: Physical Exam_____ Spinal Exam/X-Ray_____ Lab work_____

Chest X-Ray_____ MRI, CT-Scan, Bone Scan_____

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other: _____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp. ☐ Other

ACTIVE LIFESTYLE MEDICAL/CHIROPRACTIC HEALTH & WELLNESS CENTER

LAST NAME: **FIRST NAME:** **MIDDLE INITIAL:**

NICK NAME: **BIRTHDATE:** **AGE:** **TODAY'S DATE:**

Indicate which of the below you have experienced in the last 1-2 months...

1 = Never; 2 = Rarely; 3 = Occasionally; 4 = Frequently; 5 = Constantly

Eyes/Ears/Nose/Throat/Respiratory:	1	2	3	4	5
Asthma	☐	☐	☐	☐	☐
Stuffy Nose	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐
Sore Throat	☐	☐	☐	☐	☐
Chronic Cough	☐	☐	☐	☐	☐
Chest Congestion	☐	☐	☐	☐	☐
Frequent Sneezing	☐	☐	☐	☐	☐
Itchy/Watery Eyes	☐	☐	☐	☐	☐
Drainage	☐	☐	☐	☐	☐
Earache or Ear Infection	☐	☐	☐	☐	☐
Itching	☐	☐	☐	☐	☐
Hoarseness	☐	☐	☐	☐	☐
Shortness of Breath	☐	☐	☐	☐	☐
Wheezing	☐	☐	☐	☐	☐
Muscular/Skeletal:					
Muscle Aches	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Joint Pain	☐	☐	☐	☐	☐
Low Back Pain	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐
Wrist/Hand Pain	☐	☐	☐	☐	☐
Elbow Pain	☐	☐	☐	☐	☐
Shoulder Pain	☐	☐	☐	☐	☐
Hip Pain	☐	☐	☐	☐	☐
Knee Pain	☐	☐	☐	☐	☐
Ankle/Foot Pain	☐	☐	☐	☐	☐
Pain Between Shoulder Blades	☐	☐	☐	☐	☐
Cardiovascular:					
Shortness of Breath with Activity	☐	☐	☐	☐	☐

Gastrointestinal:	1	2	3	4	5
Constipation	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐
Reflux or Heartburn	☐	☐	☐	☐	☐
Bloating	☐	☐	☐	☐	☐
Gas	☐	☐	☐	☐	☐
Nausea or Vomiting	☐	☐	☐	☐	☐
Chrohn's Disease	☐	☐	☐	☐	☐
Stomach Pains or Cramping	☐	☐	☐	☐	☐
Urinary:					
Frequency	☐	☐	☐	☐	☐
Urgency	☐	☐	☐	☐	☐
Burning or Pain	☐	☐	☐	☐	☐
Blood in Urine	☐	☐	☐	☐	☐
Incontinence	☐	☐	☐	☐	☐
Skin:					
Rashes	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Itching	☐	☐	☐	☐	☐
Dryness	☐	☐	☐	☐	☐
Loss of Hair	☐	☐	☐	☐	☐
Excessive Sweating	☐	☐	☐	☐	☐
Neurological:					
Headaches	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Numbness	☐	☐	☐	☐	☐
Tingling	☐	☐	☐	☐	☐

Endocrine/Hormone:	1	2	3	4	5
Weight Loss or Gain	☐	☐	☐	☐	☐
Inability to Lose Weight	☐	☐	☐	☐	☐
Hypo/Hyper Thyroid	☐	☐	☐	☐	☐
Change in Appetite	☐	☐	☐	☐	☐
Fatigue or Drowsiness	☐	☐	☐	☐	☐
Poor Sleep	☐	☐	☐	☐	☐
Decreased Endurance	☐	☐	☐	☐	☐
Feel "Burned Out"	☐	☐	☐	☐	☐
Hot Flashes or Night Sweats	☐	☐	☐	☐	☐
Reproductive:					
Pain During Sex	☐	☐	☐	☐	☐
Low Sex Drive	☐	☐	☐	☐	☐
Erectile Dysfunction	☐	☐	☐	☐	☐
Mental/Emotional:					
Anxiety	☐	☐	☐	☐	☐
Stress	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐	☐
Foggy Thinking	☐	☐	☐	☐	☐
Forgetfulness	☐	☐	☐	☐	☐
Mood Swings, Irritability or Grumpiness	☐	☐	☐	☐	☐
Other:					
Fever or Chills	☐	☐	☐	☐	☐
Weakness	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐

Which conditions/symptoms bother you the most?

How long have you been bothered by these conditions?

Describe how it feels or affects you when it is at its worst?

If you could eliminate one of the above, which would it be?

What are your health goals?