Active Lifestyle Chiropractic

Patient General Information Questionnaire

Section 1 – Personal Information

Name: _____ Today's Date: _____
Birth Date: _____/_____/_____ Age: _____ Sex: ☐ M ☐ F
If minor, Name of parent or guardian: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: H: _____ W: _____ C: _____
Current Employer: _____
City: _____ Contact phone: _____
Job Description: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children: _____
Emergency Contact: _____ Phone: _____
Insurance Provider: _____
Policy Holder: _____ Policy Holder DOB: _____/_____/___
How were you referred to our office? _____
Would you like to receive a monthly health newsletter via e-mail? Yes No Promotions? Yes No
If yes, please write your E-mail address: _____

Section 2 – Current Health Condition

What is your primary health concern: _____
Have you had this concern or something similar before: Yes No When: _____
When did it begin: _____
Have you tried anything for it (meds, ice, heat, other health professional, etc.): Yes No
If yes, what: _____ Did it help: Yes No A Little

Section 3 – Current and Past Health History

Please list **ALL** current and past major health concerns, such as chronic illnesses, co-morbidities, and conditions (i.e. diabetes, cancer, arthritis, anemia, heart disease, liver disease, etc.)

_____

_____

Please list **ALL** accidents, injuries, surgeries, and hospitalizations below. If none, please write: ***None***
Accidents, Injuries, Fractures (Year): _____

_____

Surgeries (Type and Year): _____

_____

Hospitalizations (Year and Reason): _____

_____

Please list **ALL** medications taken and state what they are for. This includes over- the-counter medication and nutritional supplements. If none, please write: ***None***

_____

_____

_____

Please mark **ALL** of the following conditions that you have currently or have ever had:

- ☐ Cancer
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Asthma
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ OCD
- ☐ Frequent Headaches
- ☐ Migraines
- ☐ Psoriasis
- ☐ Emphysema
- ☐ COPD
- ☐ STDs
- ☐ HIV/AIDS

Please mark **ALL** of the following you have had during the past **SIX (6)** months:

Musculoskeletal:
- ☐ Low back pain
- ☐ Mid back pain
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Hand/wrist pain
- ☐ Hip/Leg/Knee pain
- ☐ Ankle/foot pain
- ☐ Jaw pain/clicking
- ☐ General stiffness
- ☐ Difficulty walking

Nervous System:
- ☐ Numbness
- ☐ Weakness
- ☐ Muscle twitching
- ☐ Muscle spasm
- ☐ Dizziness/Vertigo
- ☐ Fainting
- ☐ Excessive stress

General:
- ☐ Fatigue
- ☐ Insomnia
- ☐ Headaches (regular)
- ☐ High fever

Circulation/Respiration:
- ☐ Chest pain
- ☐ Heart Problems
- ☐ High blood pressure

Genito-Urinary:
- ☐ Bladder trouble
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Discolored urine

- ☐ Lung problems
- ☐ Shortness of breath
- ☐ Excessive ankle swelling

Gastro-Intestinal:
- ☐ Loss of appetite
- ☐ Excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Sudden weight loss
- ☐ Excessive weight gain
- ☐ Black stool
- ☐ Bloody stool
- ☐ Abdominal cramps
- ☐ Abdominal pain
- ☐ Liver trouble
- ☐ Gall bladder trouble

Head/Neck:
- ☐ Blurred vision
- ☐ Double vision
- ☐ Teeth grinding
- ☐ Dental problems
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Difficulty swallowing

Male/Female:
- ☐ Prostate trouble
- ☐ Vaginal infection
- ☐ Ovarian cysts

Please answer the following questions to the best of your ability.

Female only:
Are you currently Pregnant? Yes No
If yes, how far along are you? _____

Daily Perceived Stress Level
Low High
0 1 2 3 4 5 6 7 8 9 10
Do you find yourself easily agitated or frustrated? Yes No

Routine Exercise
Do you exercise regularly at least once a week? Yes No
If yes, please describe: _____
Frequency: _____times/week Duration: _____/min/hours

Sleeping pattern:
Average hours of sleep per night: _____
Do you consider it restful? Yes No
Do you awake frequently? Yes No
Do you find yourself tiring often or easily? Yes No

Family History
Please mark **ALL** found in your family, including extended
- ☐ Heart disease
- ☐ Diabetes
- ☐ Cancer

Do you currently or have you ever used any of the following with regularity? All information is completely confidential.
Tobacco Use: ☐ Yes ☐ No
Packs/day: ____ Years:____
Alcohol Use: ☐ Yes ☐ No
☐ Occasional ☐ Social ☐ Other
Illicit Drug Use: ☐ Yes ☐ No
Please list: _____

A ☐ N ☐

Informed Consent and Office Policies

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include medical history, spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays/MRIs).

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.
In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, bruising, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

CONSENT:
I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.
I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DAEDALUS HEALTH SERVICES, LLC (dba Active Lifestyle Chiropractic) TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____

Patient Signature

_____

Doctor's Signature

Parental Consent for Minor Patient: Patient Name: _____ Patient age: _____ DOB: _____ Printed name of person legally authorized to sign for Patient: _____ Signature: _____ Relationship to Patient: _____		In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care. Please list anyone who is given permission to bring Child in for treatment without you being present as well as their relationship to the child: _____ _____ _____ Printed name of person legally authorized to sign for: Patient: _____ Signature: _____ Relationship to Patient: _____

Treatment

I hereby authorize the Doctor to treat my condition as he deems appropriate. This may include, but is not limited to: physical examinations and re-examinations, spinal and extremity adjustments, soft tissue therapies, intersegmental traction, electrical stimulation, cold laser therapy, spinal decompression, active rehabilitation, and recommendations of nutritional supplements and/or activity/lifestyle modifications.

I understand that ultimately my health is my responsibility and it is up to me to follow through with my treatment, keep my appointments, and follow appropriate health, activity, and lifestyle modifications. I understand if I do terminate care prematurely or do not follow appropriate recommendations the condition I am being treated for may not fully resolve or may return sooner than anticipated, and may even be worse. I agree that if I terminate care prematurely or do not follow recommendations to not blame Dr. Robb, Active Lifestyle Chiropractic, or chiropractic, in general, if the condition is not fully resolved or returns sooner than anticipated.

Imaging

X-rays or MRIs will be requested when deemed necessary during the initial or any subsequent visits. In some cases, Dr. Robb will not treat certain patients until the imaging has been taken and read by a radiologist. All imaging is later reviewed with the patient once we receive the report from the radiologist. All patients are referred out to a local imaging center or to their primary care providers for imaging. The local imaging centers accept most, if not all, insurances.

I understand that it is the Doctor's decision whether or not images need to be taken. If I refuse to receive the appropriate imaging, I understand that the Doctor may refuse to treat me. Furthermore, I understand that I may request to receive imaging at any time and Dr. Robb will promptly refer me to an imaging center. I also understand that I will be referred to an outside office or company to acquire the necessary imaging and that any expense incurred is my responsibility.

Insurance and Payment

Active Lifestyle Chiropractic is a preferred/participating provider in many insurance companies. Active Lifestyle will obtain and discuss the insurance benefits with the patients as soon as they are able to obtain the benefit information. There are a number of variables with insurances. For example, co-payment amounts and deductibles vary greatly. In some cases, it is more affordable to pay out of pocket, at the time of service, which may include the option of a care plan, than to use insurance. When the office goes over the benefits the patient may choose to use their insurance or pay out of pocket, at the time of service, which includes a care plan option. I understand that if I have insurance and choose to pay for my care out of pocket or purchase a care plan that I will be waiving my right to have insurance billed and the amount to be applied toward my deductible. Conversely, if I elect to use my insurance I understand that I am fully responsible to pay my deductible, co-pays, and co-insurances in full. I understand that all co-pays and/or cash payments are due at the time of my visit.

To ease the patient burden of large balances due, I understand that if I have a deductible Active Lifestyle will collect $50 from me each office visit, which amount will be applied directly to the deductible and my account. I understand that this amount will most likely not satisfy the full deductible balance as determined by the insurance companies and I will receive a statement for the balance. I also understand that if there is an overpayment Active Lifestyle will reimburse me the excess balance. I understand that if I have a co-insurance Active Lifestyle will collect $10 from me each office visit. I understand that this amount may not fully satisfy the co-insurance balance and if it does not Active Lifestyle will send me a statement for the balance. I also understand that if there is an overpayment of the co-insurance Active Lifestyle will reimburse me the excess balance.

I understand that I am personally and fully responsible to pay any amount that my insurance policy(s) state I owe. I understand that Active Lifestyle will bill me directly if there is a balance on my account. I also fully understand that reduction and rejections of claims by my insurance provider does not in any way affect my obligation to pay the balance on my account in full. I authorize Active Lifestyle Chiropractic to use any necessary means to collect any past due balances on my account. I agree to pay any and all collection, court, and attorney fees in association with the collection of my account.

If at any time there has been an overpayment made by the insurance company or the patient, Active Lifestyle will issue a refund either to the Insurance provider or the patient directly, depending on the circumstances.

Odds and Ends

I understand the office offers a variety of rehabilitative therapies (physiotherapy), including active rehabilitation. I understand that I may be placed on therapeutic modalities or asked to perform active rehab activities either before or after an adjustment, in order to help maintain patient flow. I also understand this decision may also be based on my own personal case and treatment. If I have a preference as to when I would like to participate in the therapeutic activities during a visit the office will honor my request unless there is a specific reason based on my condition and treatment; if that is the case the doctor will discuss this with me.

I understand that there are a number of activities in the office that I may be participating in that are unsupervised. These include, but are not limited to: therapeutic exercises, spinal decompression, electrical stimulation, intersegmental traction, etc. I understand the staff will prepare me and the equipment for all therapeutic activities and that most are unsupervised, particularly after the initial visit. I understand that the staff encourages and welcomes any questions or concerns and it is my responsibility to voice my questions or concerns to the office staff.

I understand that the Chiropractic Assistants (CAs) and Athletic Trainers in the office are not health care professionals. I recognize that they have been sufficiently trained to perform the tasks asked of them and are highly proficient at their job. However, I understand that they are not legally allowed to provide any health care advice or answer any questions pertaining to my personal health or treatment. As such, I understand that if I have any questions regarding my treatment, health, or any question the CA is unable to answer I am to ask Dr. Robb directly. I further understand that any information received from a CA regarding my treatment, health, etc should be regarded as opinion and nothing more.

Privacy Information

Active Lifestyle Chiropractic is fully HIPPA compliant. Your information will not be shared with anyone other than those who require the information (i.e. your insurance company) and those who you agree to have your information disclosed to (lawyers, etc). You have been provided with a short pamphlet titled "Your Privacy is Important to Us" that explains the privacy policies and practices of the clinic. Please take the time to read through the packet.

Disclosure of Fees

By Utah law we are required to disclose our price list, which includes insurance billing codes (CMT Codes). As this list can be confusing it is available upon request.

By my signature I attest that I have read, understand, and agree to all of the information listed in the Treatment, Imaging, Insurance and Payment, Odds and Ends, Privacy Information, and Disclosure of Fees sections.

Signature: _____ Date: _____