Confidential **Patient** Profile

Name: ________________________________

Address: ________________________________

City:_______________ State: ____ Zip: ________

Birth date:___________ Age: _____ Gender: M F

SS #:_______________ DL #: ________________

Home Phone #: ( ) ________-___________

Cell Phone #: ( ) ________-___________

Cell Phone Carrier: ☐Verizon ☐ T-Mobile ☐ AT&T ☐Sprint ☐ U.S. Cellular ☐ Other________

E-Mail Address: ____________________________

Referred By: ______________________________

Employer: ______________________________________

Work Phone #: ( ) _________-______________

Marital Status: ____ Spouse's Name: _______________

Spouse's Employer: _______________________________

Spouse's Birth Date (if policy holder): ______________

Children & Ages: _______________________________

____

Health Insurance Carrier: __________________________

Member ID & Group #: ____________________________

☐ Flex Spending Account ☐HSA account

As a lifestyle and wellness based chiropractic center, we focus on your ability to be healthy. Our goals are first, to address your immediate concerns that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness in the future. On a daily basis we adapt to physical, bio-chemical, and emotional stresses that can accumulate over time. Improper adaptation to these stresses may result in a serious loss of health and well-being. In most cases these effects are gradual and not even felt until they become serious. By answering the following questions you will give us a profile of the specific health challenges you have faced which allows us to better assess the challenges to your full health potential, and allows us the information needed to give you our best recommendations.

Immediate Concern:

☐ **If you do not have a current complaint and are here for Chiropractic Wellness Services please check the box and skip to the next section, otherwise please continue:**

What current health challenges are you experiencing (Pain/Symptoms/Conditions)? ________________________________

____

Date Began: _____________ Have you experienced this condition before? Y N If yes, when: __________________

How often does this condition bother you? ___________________ Is the condition getting better or worse? ____________

When is it at its worse? _______________________ Severity of complaint (Scale 0-10 / 10 being the worst): __________

Is the pain local or does it travel / radiate? _______________________ Is this condition work or auto accident related? Y N

Has this condition affected any of the following? ☐ Sleep habits ☐ Work ☐ Leisure ☐ Exercise Habits ☐ Mental Attitude

Have you seen anyone else for this condition? ____________________________________ Were you helped? Y N

List all medications/supplements you are currently taking: (Prescription and Non-Prescription) ________________________

____

How does your main complaint affect your life? ____

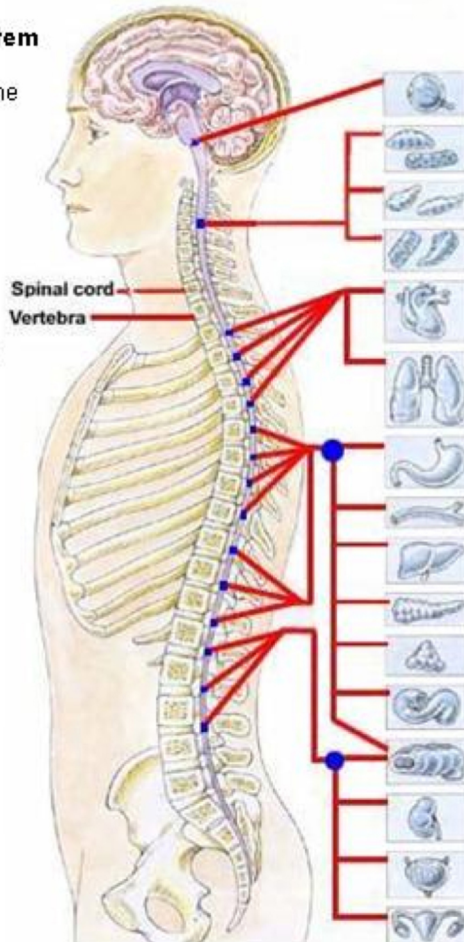
____

Personal Health History

Your nervous system controls and coordinates every function of your body. Symptoms may be a sign of neurological disturbance and/or dysfunction. Please specify accordingly by marking a **(C)** if you are *currently* or a **(P)** if you have *previously* experienced any of these symptoms so that we can properly evaluate the function of your nervous system.

Motor & Sensory Nervous System

___ Tension/Cervicogenic Headache
___ Dizziness/Loss of Balance
___ Jaw Pain/Clicking
___ Neck Pain
___ Arm/Hand Pain
___ Arm/Hand Numbness/Tingling
___ Mid Back Pain
___Scoliosis/Spinal Curvature
___ Arthritis
___ Stiff/Painful Joints
___ Muscle Pain/Soreness
___ Muscle Spasm/Trigger Points
___ Low Back Pain
___ Hip Pain
___ Leg/Foot Pain
___ Leg/Foot Numbness/Tingling
___ Other: ________________
___ Other: ________________



Autonomic Nervous System

___ Vision changes	___ Fatigue
___ Vertigo	___ Migraines
___ Sinus Congestion	___ Allergies
___ Frequent Colds	___ Brain Fog
___ Nervousness	___ Insomnia
___ Heart Problems	___ Chest Pain
___ Lung Problems	___ Asthma
___ Heartburn	___ Indigestion
___ Ulcers	___ Bloating
___ Liver Problems	___ Immune Deficiency
___ Diabetes	___ Tiredness
___ Stress/Anxiety	___ Depression
___ Digestion Problems	___ Cramping
___Constipation	___ Diarrhea
___ Kidney Problems	___ Urinary Problems
___ Prostate Problems	___ Sexual Dysfunction
___ Menstrual Pain	___ Infertility
___ Other: ________	___ Other: ________

Family History

	Heart Disease	Cancer	Diabetes	Arthritis	Other
Father's Side	☐	☐	☐	☐	☐ ____________________
Mother's Side	☐	☐	☐	☐	☐ ____________________
Spouse	☐	☐	☐	☐	☐ ____________________
Children	☐	☐	☐	☐	☐ ____________________

Neurological Health and Spinal Maintenance History

Have you ever had Chiropractic care before? Y N Name of Doctor or Office: ________________________________

Have you ever had spinal X-rays? Y N If yes, approximate date: ____________ Do you wear orthotics or heel lifts? Y N

Have you ever had any surgery? Y N If yes, please explain ____

Have you had any recent accidents, work or sport injuries? Y N If yes, please explain: ______________________

____

Current Health Habits

Please list your top stresses in each of the following categories:

Physical Stress (work, hobbies, posture, accidents, etc.): ____

Biochemical Stress (eating habits, smoke, work environment, medications, etc.): ______________________________

Psychological Stress (work, relationships, self-esteem, finances, etc.): ___________________________________

Are you aware that stresses such as the ones above largely contribute to your current health condition/status? Y N

If yes, have you ever tried to improve upon those stresses affecting your current health status? Y N

Personalization of Care

Your satisfaction is our ultimate goal therefore we will do our best to customize your care to your personal preferences. There are many techniques and services offered in the chiropractic and healthcare fields, if you have had a previous experience (favorable or not) please indicate so along with any other preferences you may have so that we can provide the best service to you as possible.

Please check the box that is most appropriate for you:

☐ I prefer traditional manual chiropractic adjustments (Manual joint manipulation i.e. popping and cracking)

☐ I prefer low force chiropractic techniques (Torque Release/Integrator Method, Drop table, Toggle, etc.)

☐ I would like the doctor to recommend the techniques best suited for my individual condition/concerns

I am or may be interested in the following:

☐ Therapeutic Massage

☐ Craniosacral Therapy

☐ Naturopathy (Nutritional therapy, homeopathy, herbal therapy, acupuncture/acupressure, etc.)

☐ Lifestyle/Health/Weight Loss Counseling or Coaching

☐ A Comprehensive Wellness Program (A complete program consisting of customized strength & cardiovascular exercise programs, nutritional supplementation & meal planning, personal development & stress reduction, personalized coaching, etc.

I attest that the statements made above are accurate and complete, and I agree to allow this office to proceed with further evaluation as deemed appropriate by the doctor. I understand that all fees (if any) are due at the time of service:

► **Patient Signature:** ____ **Date:** _____/______/_________

Thank you for filling out this form. It is your first step towards Health & Wellness!
Please return this form to our front desk and someone will be right with you.

We would love to help you help others! Who do you know would be interested in a FREE Health Checkup?

1. NAME: __________________________ ***Phone Number:*** ______________ ***Email:***___________________________

2. NAME: __________________________ ***Phone Number:*** ______________ ***Email:***___________________________

3. NAME: __________________________ ***Phone Number:*** ______________ ***Email:***___________________________

Authorization of Care

I hereby authorize Dr. Philip Que and staff to work with my condition through the use of methods within the Chiropractic scope, as he deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me, or billed to my insurance carrier. I agree that I am ultimately responsible for all fees and bills incurred at this office. In the event that my insurance carrier does not reimburse Active Living Chiropractic LLC for professional services performed, I understand that I will be billed for all fees outstanding. Active Living Chiropractic LLC will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Active Living Chiropractic LLC, for services rendered. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself, and that Active Living Chiropractic LLC will not be a mediator.

Ownership of X-ray Films: *It is understood and agreed that the payments (if applicable) to Active Living Chiropractic LLC for X-rays are for the information and examination on the X-rays only. The x-ray negatives will remain the property of Active Living Chiropractic LLC.*

Signature:____ Date:_____________________

Guardian or Spouse Authorization Signature:____

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well-being, not merely the absence of sickness or disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care

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provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom.

I have read and fully understand the above statement. Any questions regarding Active Living Chiropractic LLC's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature:____ Date:______________________

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Policy. A more complete description can be requested. I also understand that I can request, in writing, that this office restrict how my personal information is used and or disclosed.

Signature:____ Date:______________________

Guardian or Spouse Authorization Signature:____

Active Living Chiropractic

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