



ACTIVELIFE
FAMILY CHIROPRACTIC

4701 Old Cheney Rd., Ste. C
Lincoln, NE 68516

(P) 402-420-0440 (F) 402-420-0443

Email: ALFCDC@gmail.com

Website: www.activelifefamilychiropractic.com

Health Information and Health History

First Name: _____ Middle Initial: _____ Last Name: _____

Gender: Male Female Marital Status: (Circle One) Married Single Divorced Widowed

Date of Birth: ____/____/____ Patient's Social Security Number: ____-____-____

Patient's Address: _____ City: _____ Zip Code: _____

Patient's Phone Number: ____-____-____ Cellular Number: ____-____-____

Email: _____

Spouse's Name: _____

Spouse's Date of Birth: ____/____/____ Spouse's Phone Number: ____-____-____

Patient's Employer: _____

Occupation: _____ Referred By: _____

Is Your Spouse Employed? Yes No

If yes, who is their Employer? _____

Is this condition due to: Auto Accident Personal Injury Work Related Accident

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Company Name: _____ ID #: _____

Do you have more than one insurance? Yes No Are you covered by Medicare? Yes No

If yes, Subscriber's Name: _____ Date of Birth: ____/____/____

I authorize Active Life Family Chiropractic to release medical information to my insurance company:

Signature: _____ Date: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay. I also understand that payment of services is due at the time of service unless other financial arrangements have been made.

Signature: _____ Date: _____



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COMPLAINTS

Primary Complaint? _____

Secondary Complaint? _____

When did your problems begin? _____

How did your problem begin? _____

Is this problem interfering with your: (Circle One)

Activities of Daily Living Work Social Activities Hobbies Sleep

Rate your pain: (Circle One) 0 being no pain or 10 being the worst pain

0 1 2 3 4 5 6 7 8 9 10

When is your health problem the worst: (Circle One) Morning Day Evening Night

Does your health problem occur: (Circle One)

Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Is your problem getting: (Circle One) Better Worse Staying the Same

Have you had this problem before? _____ When? _____

What aggravates your health problem: circle all that apply and others _____

Coughing Sneezing Walking
Reaching Lifting Bending
Sitting Lying Down Standing
Neck Movement Straining at Stool

What relieves your health problem: circle all that apply and others _____

Nothing Resting Heating
Sitting Standing Ice

Have you had recent treatment for this condition? Yes No

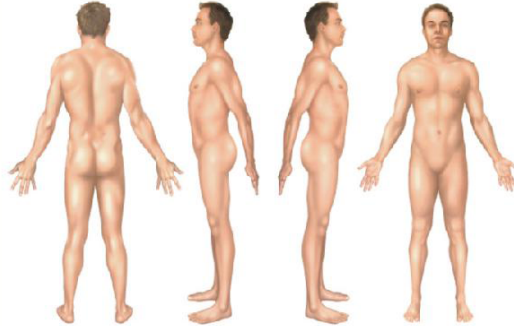
Who did you see? _____ Treatment _____

Have you had any changes in bowel or bladder habits since your problem began? Yes No

Health Information and Health History

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

(Numbness) X (Burning) / (Stabbing) 0 (Pins & Needles) + (Dull Ache)



What describes the nature of your symptoms?

Sharp Dull Aches Numb Shooting
 Burning Tingling Stabbing

MEDICAL HISTORY

Have you seen a doctor of chiropractic? Yes No

If yes, Office Name: _____ Address/Zip Code: _____

Chiropractor's Number: _____ - _____ - _____

Who is your Family Physician: _____ Date of last physical exam:

___ / ___ / ___

Do you give us permission to send your family doctor your progress and treatment notes? Yes No

If yes, Office Name: _____ Address/Zip Code: _____

Family Doctor's Number: _____ - _____ - _____

Have you been hospitalized in the past five years? Yes No

If yes, Date(s) & Reasons: _____

Have you had any serious accidents in the past five years? Yes No

If yes, Date(s) & Reasons: _____

List your medications: _____



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In the past 6 months have you suffered from: circle all that apply or circle normal

General:

Fatigue Weakness Weight Change Loss of sleep Normal

Neurological:

Headaches Seizures Dizziness Nervousness Normal

Eyes:

Vision Trouble Dryness Redness Cataract Glaucoma Normal

Nose:

Pain Bleeding Sinus Trouble Infections Normal

Mouth/Throat:

Sores Bleeding Enlarged Glands Tonsillitis Normal

Cardiovascular:

Coughing Sneezing Wheezing Chest Pain Normal

Palpitations Hypertension

Gastrointestinal:

Diarrhea Vomiting Appetite Change Heartburn Normal

Constipation Gas

Endocrine:

Goiter Sugar in Urine Heat Intolerance Cold Intolerance Normal

Psychological:

Anxiety Depression Memory Loss Mood Swings Normal

Have you ever had any of the following: (Circle all that apply)

Arthritis	Heart Trouble	Pacemaker
Diabetes	Dislocated Joints	Hay Fever
Asthma	Bone Fracture	Tuberculosis
Epilepsy	High Blood Pressure	Serious Injury
Allergies	Low Blood Pressure	Prostate Trouble
Sinus	Rheumatic Fever	Kidney Trouble
Scoliosis	Spinal Disease	Polio
Cancer	Thyroid Trouble	HIV
Ulcer	Sexually Transmitted Disease	AIDS

Health Information and Health History

FAMILY HISTORY

Do you have a child(ren)? Yes No

If yes, how many and their names? _____

List your hobbies: 1) _____
2) _____
3) _____

What are your habits?	Smoking	never	packs per day _____
	Alcohol	never	drinks per day _____
	Caffeinated Drinks	never	drinks per day _____
	Exercise	never	times per week _____
	Drug/Substance Abuse	never	if yes discuss with your

doctor **Has anyone in your family had any of the following:** (if yes list relationship to patient)

Cancer: _____ Diabetes: _____
Heart Trouble: _____ High Blood Pressure: _____

Do any family members suffer from the following: (if yes list relationship to patient)

Neck Pain: _____
Back Pain: _____
Headaches: _____
Arthritis: _____
Disc Problems: _____
Pinched Nerves: _____
Bad Posture: _____
Scoliosis: _____
Osteoporosis: _____

Doctor's Signature: _____



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What type of treatment have you had since the accident? _____

Are you taking medication due to injuries from this accident? Yes No

If yes, what type of medication? _____

Were x-rays or special test performed following the accident? Yes No

If yes, list name or facility where tests were performed: _____

Do you have additional symptoms or complaints that have occurred since the accident? Yes No

If yes, please list: _____

Is there any additional information you would like us to know?

Office Use Only: Doctor's Notes _____

Health Information and Health History

WORK INJURY QUESTIONNAIRE

Patient Name: _____ Gender: Male Female

Date of Injury: ___/___/___ Time of Accident: ___:___ a.m. p.m.

Did you report this injury to your employer? Yes No Who did you report it to? _____

What caused the injury? _____

Describe in your own words that happened? _____

What is your major complaint? _____

Do you have any secondary complaints as a result of this accident? _____

Have you missed work due to this injury? Yes No If yes, how many days? _____

Describe your job duties: _____

Additional Information: _____



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