ACTIVE LIFE FAMILY CHIROPRACTIC

4141 Pioneer Woods Dr. #116 | 2555 Kensington Dr. | 8244 Northern Lights Dr. #106
Tel: (402)420-0440 & Fax: (402)420-0443

STAFF INITIALS _____
ACCOUNT NUMBER _____

New Patient Registration

Legal Name: _____ Date: _____
LAST FIRST MIDDLE

Preferred Name: _____ Age: _____ Date of birth: _____

Address: _____ Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name:_____ DOB: _____ Spouse's Employer: _____

Whom may we thank for referring you? _____

In case of emergency, notify_____ **Relationship:** _____ **Phone:** _____

Who is responsible for this account? _____ **Relationship to patient:** _____

Insurance Information
Do you have more than one insurance? __ Yes __ No Do you have Medicare/Medicaid? __ Yes __ No

Insurance Carrier _____ ID number _____

Subscriber name _____ Relationship _____ Subscriber DOB _____

I understand and agree that health and accident policies are an arrangement between my 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. I authorize Active Life Family Chiropractic to release medical information to my insurance company.

Signature _____ **Date** _____

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

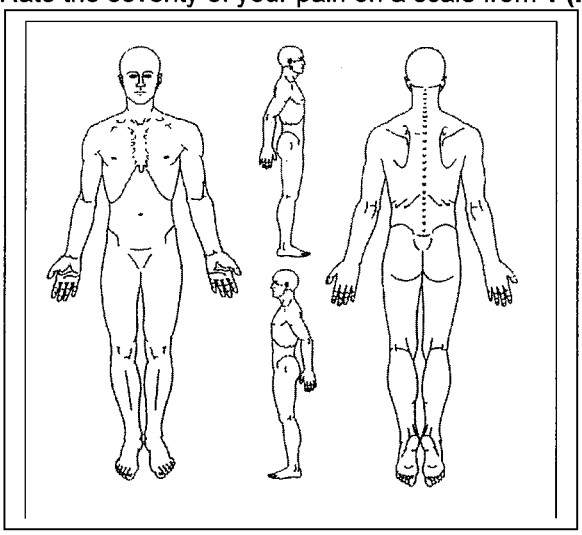
Patient Signature: _____ **Date:** _____

I give Active Life Family Chiropractic permission to release the following: __ Medical/Treatment Information
__ Account/Payment Information

To _____
(name of person and relationship)

_____ _____
Signature **Date**

Current Symptoms / last 30 days: Rate the severity of your pain on a scale from **1 (least pain) to 10 (severe pain)**
(mark symptoms on body in box)



1._____ Pain Level _____
Circle the type of pain (ache, burn, dull, sharp, throbbing, tingling, numb)
When did it begin?_____ What makes it better?_____ Worse?_____
Are symptoms ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

2._____ Pain Level _____
Circle the type of pain (ache, burn, dull, sharp, throbbing, tingling, numb)
When did it begin?_____ What makes it better?_____ Worse?_____
Are symptoms ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

3._____ Pain Level _____
Circle the type of pain (ache, burn, dull, sharp, throbbing, tingling, numb)
When did it begin?_____ What makes it better?_____ Worse?_____
Are symptoms ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

4._____ Pain Level _____
Circle the type of pain (ache, burn, dull, sharp, throbbing, tingling, numb)
When did it begin?_____ What makes it better?_____ Worse?_____
Are symptoms ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

What daily activities would you like to see improve? _____

What are your goals for care? _____

CHECK ANY OF THE FOLLOWING SYMPTOMS:

☐ Headache	☐ Middle Back Pain	☐ Lower Back Pain	☐ Ears Ring
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ Buzzing in Ears
☐ Neck Stiffness	☐ Bruised Chest	☐ Radiating Pain	☐ Dizziness
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ Depression	☐ Blurred Vision	☐ Tingling in Arms	☐ Loss of Taste
☐ Anxiety	☐ Sensitivity to Light	☐ Jaw Pain	☐ Any Burns
☐ Fainting	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ Any Stitches
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ Any Cuts

Is condition due to an accident? Yes__ No__ Date of injury:_____ Type of accident: Auto___ Work ___

Are you pregnant? ☐ **Yes** ☐ **No** Due date: _____ **Date of last menstrual cycle**: _____

What treatment have you already received for your condition?

Medications _____

Surgery _____ Physical Therapy _____ Orthopedic _____

Have you previously seen a Doctor of Chiropractic? __ Yes __No Number of visits seen *this* year _____

Name of Chiropractor: _____ City/State: _____

Name of Primary Care Physician: _____

Office Name: _____ Address: _____

Would you like us to send your Primary Physician a copy of our initial report? ☐ Yes ☐ No

Date of Last: Physical _____ Spinal X-ray _____ Spinal Exam _____ MRI or CT Scan _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

Please list all serious illnesses and accidents:

Falls/Head Injuries_____ Date:_____

Surgeries_____ Date:_____

Broken Bones_____ Date:_____

Lifestyle:

Exercise	**Work Activity**	**Habits**	
___None	___Sitting	___Smoking	Packs/Day _____
___Moderate	___Standing	___Alcohol	Drinks/Week _____
___Daily	___Light Labor	___Coffee/Caffeine Drinks	Cups/Day _____
___Heavy	___Heavy Labor	___High Stress Level	Reason _____

List your hobbies:

_____

_____

Consent to Chiropractic Services

1. I request and consent to the performance of the following procedures: initial consultation, examination, x-rays, chiropractic adjustments, and chiropractic modalities on me (or the patient named here, for whom I am legally responsible _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unknown conditions, that the chiropractic physician, associates, or assistants may consider necessary or advisable in the course of my healthcare.

3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences and the possibility of complications have been explained to my satisfaction by the chiropractic physician, associate, or assistants.

4. Acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by the above chiropractic physician, associate, or assistant.

To be completed by the patient:

_____	_____	_____
Print Name	**Signature**	**Date**

To be Completed by the patient's representative and or guardian, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated):

_____	_____
Name of Patient	Print Name of Representative
_____	_____
Signature of Representative	Date

Consent to Digital Communication

I authorize Active Life Family Chiropractic to send text message and/or email communication to me. I understand that I may reply with various commands to receive account information such as balances, future appointments, office location and other alerts. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account holder and/or dependents. Text message charges from my cell phone provider may apply.

_____	_____	_____
Print Name	**Signature**	**Date**

Neck Index

Form N1-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date***

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

ACTIVELIFE
FAMILY CHIROPRACTIC

Electronic Health Records Intake Form

This form complies with CMS EHR program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders:
(Circle one): Email / Phone / Text (Cell Carrier: _____)

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I would like to receive my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____