Active Life Chiropractic
2804 Forum Blvd Ste. 1A
Columbia, MO. 65203

Full Name:_____ Nickname:_____ Today's Date_____
Address:_____
City:_____ State:_____ Zip_____ Date of Birth:_____
Home#:_____Work#:_____Mobile#:_____
SS#:_____Email:_____
Sex:☐Male☐Female Status:☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Occupation:_____Employer:_____

Emergency Contact:_____ Phone:_____
Relationship:_____

Who may we thank for referring you to our practice? _____
Primary Physician:_____ May we update them about your care? ☐ Y ☐ N

Chiropractic History:
Have you had previous chiropractic care? ☐Y ☐N If yes, whom? _____
Reason for care:_____ Did it help? _____
What type of care did you receive? ☐Relief ☐ Correction ☐ Wellness/Preventative
Why are you changing chiropractors? _____

Insurance Information
☐ I plan to utilize my primary health insurance health insurance policy
☐ I have a secondary insurance policy
☐ I am a self-pay patient (I have no health insurance, or insurance that does not offer chiropractic coverage
☐ I am a Veteran ☐ I am currently active in the United States Military and or Reserves

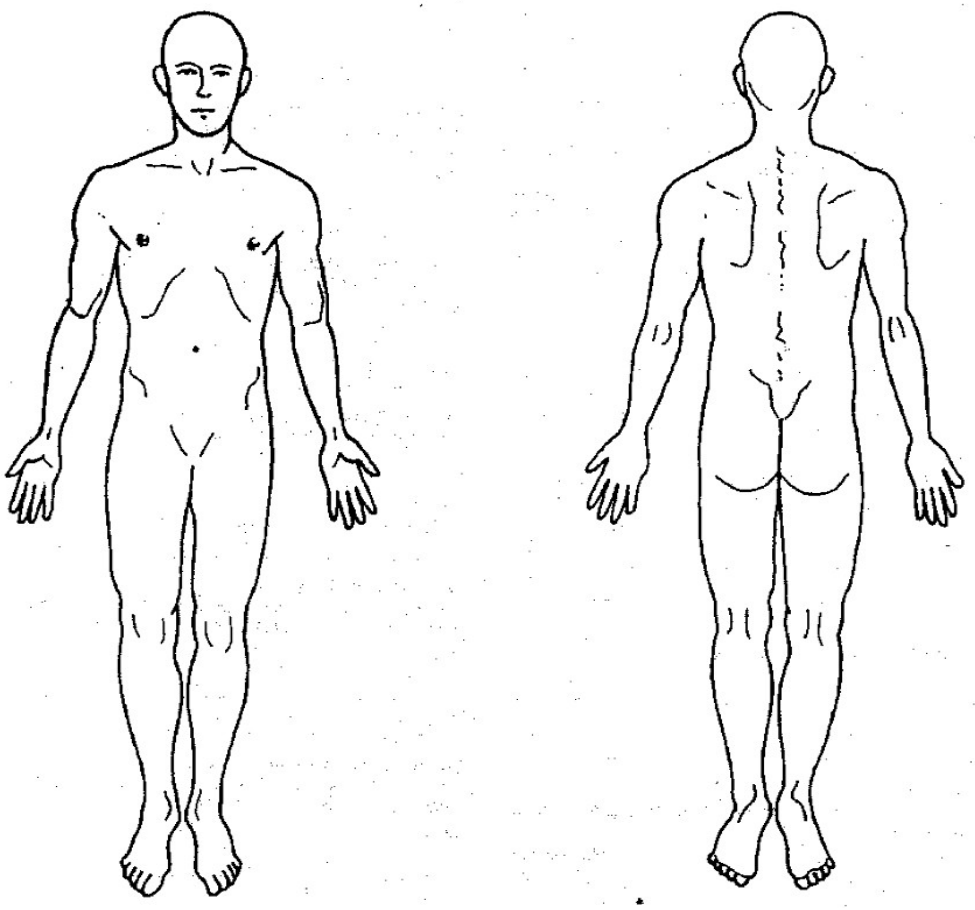
Is today's visit due to: ☐ auto accident ☐ personal injury ☐ work accident ☐ old injury ☐ new injury

Please provide the front desk with a driver's license and a current insurance card if applicable

We are passionate about partnering with you in your health and wellness care. To understand your individual health goals, please check all that apply:
☐ Symptomatic/temporary relief ☐ Maximum Correction ☐ Improved Performance

☐ Holistic Health Management ☐ Wellness and Prevention ☐ Other

Patient Name:_____ Date of Exam:_____
On the diagram below, please illustrate any symptoms you may be experiencing by circling a body region or drawing a line along the path of pain and labeling that area.



Please identify your main complaints/concerns in the order of severity.
Approximate date of onset: Severity: (1 = very low pain: 10 = unbearable pain)
Complaint:_____ 1 2 3 4 5 6 7 8 9 10 _____% of the time

What makes it worse ? What makes it better ? Time the pain is at it's worst ? What setting is the pain at it's worst ?

_____

_____

Complaint:_____ 1 2 3 4 5 6 7 8 9 10 _____% of the time

If more complaints please list on the back.

General Health and Wellness Questionnaire

How are these complaints/concerns affecting your quality of life? (Please check only those applicable to you).

☐ Work/School ☐ Walking ☐ Sitting☐ Mood ☐ Exercise/Sports ☐ Eating ☐ Relationship ☐ Engery ☐ Recreation/Hobbies ☐ Sleep ☐ Daily Routines ☐ Other

Lifestyle/Social History

On a scale of 1-10, please rank your psychological/emotional stress levels in each category (1=none/10=extreme): Occupational:____ Personal:____

On a scale of 1-10 (1=poor/10=excellent), please describe your:
Eating habits:____ Exercise habits:____ Sleep:____ General health:____
List your unhealthy lifestyle habits (i.e. Smoking,alcohol, junk food):_____

Medical History (Birth to Present)

Have you had any problems in the past or presently with any of the following systems of the body? (describe symptoms or list illness/disease)

☐ Muscle/skeletal system (broken bones, dystonia, osteoporosis, etc): _____
☐ Nervous System (MS, seizures, migraines, etc): _____
☐ Gastro-intestinal (appendix, colitis, heartburn, etc): _____
☐ Cardiovascular (heart attack, stroke, murmurs, etc):_____
☐ Respiratory (asthma, cough, shortness of breath, etc): _____
☐ Genito-urinary (incontinence, painful intercourse, etc):_____
☐ Eyes, Ears, Nose, Throat (blurred vision, ringing in ears, etc): _____
☐ Male or Female Specific (prostate, cysts, etc): _____
☐ General(fatigue/allergies/sleep/diabetes/headaches):_____

Please list any medications you currently take and why: _____
_____

Please list any nutritional supplements (i.e. vitamins, herbs) you take:_____
_____

Have you had any accidents or trauma related to any of the following? (check all that apply): ☐ Automobile ☐ Sports ☐ Falls ☐Abuse
If yes, please explain (type and date):_____

Hospitalizations and/or surgeries (type and date):_____

Family History

Please list any significant diagnosis or cause of death and age of any immediate family member (parents or siblings): _____
_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature_____Date_____