Active Family & Sports Chiropractic PLLC

1260 Gallaher Road, Suites B & C ◆ Kingston, TN 37763 ◆ (865) 248-8167 ◆ www.ActiveFamilyTN.com

□ Female
Name: ______________________________ Birthday: ____/____/____ SS#: ____-____-_____ □ Male
Address: ____________________________________City, State, Zip:_______________________
Home/Cell #: (_____)______________ Work #: (_____)________________ Email:____________________
Contact Preference: Check if: □ CELL □ WORK □ EMAIL Favorite color: ____________________ (Online Portal Security)
Occupation: ________________________ Employer: ___________________________ □Full time □Part time
Emergency Contact: __________________________Relation:____________ Phone: (_____)________________
Marital Status: □ Single □ Married □ Widowed □Divorced Race: □ White □ Black/AA □ Hispanic/Latino □ Multi/Other:____
Employer Address: ________________________City, State:_________________ Phone: (_____)________________
Health Insurance:__________________________________ Policy Holder Name: _____________________________
Policy Holder DOB: ____/____/____
Please note: additional documentation is required for Work Comp or Auto Claims. See staff if this is not a medical claim.
Primary Care Physician: ______________________________ Phone: (_____)_________________
City, State: __________________________ Last exam or visit: ____/____/____ Reason:____________________
I consent to a letter about my condition and treatment in this office be sent to my PCP, **INITIAL:** ______________
Referral from: Drive by Ad Event Website Patient/Doctor:___________________ Other:_________________

Family History

Check & Circle all of the following that apply to your FAMILY MEMBERS (Mother/Father/Brother/Sister):
□ Cancer: M / F / B / S List Type(s): _____________ □ Heart Disease: M / F / B / S □ Stroke: M / F / B / S
□ Blood Pressure: M / F / B / S □ Diabetes: M / F / B / S □ Arthritis/Rheumatoid Arthritis: M / F / B / S
□ Neurological Disorder: M / F / B / S □ AutoImmune Disorder: M / F / B / S □ Other:_____________ M / F / B / S

Personal Health History

Allergies: ____ Reaction: ______________________
Major Hospitalization/Infections/Trauma: ____
Current Medications: ____
Current Supplements/OTC: ____

Health History

Constitutional
__ Weight Loss
__ Weight Gain
__ Loss of Appetite
__ Recent Fever/Chills
__ Fatigue
__ Cancer:__________
__ Change in Bowel or Bladder Function
__ Fainting or Loss of Consciousness
__ Recent Falls

Skin
__ Frequent Rashes
__ Open Wounds
__ Skin Lesion
__ Itchy/Red Skin
__ Skin Cancer

Eye
__ Blurred Vision
__ Vision Loss
__ Double Vision

ENT
__ TMJ / Jaw Pain
__ Nose Bleeds
__ Hearing Loss
__ Ringing Ears
__ Hoarseness/Sore Throat
__ Difficult Swallowing
__ Sinus Infections

Lung/Respiratory
__ Short of Breath
__ Wheezing
__ Chronic Cough
__ Exercise Intolerance
__ Asthma

Cardiovascular
__ Chest Pain
__ Irregular Beat
__ Calf Pain
__ High Cholesterol
__ High Blood Pressure

Digestive
__ Heartburn
__ Nausea/Vomiting
__ Blood in Stool
__ Liver/Gallbladder

Kidney/Bladder
__ Painful Urination
__ Problems Urinating
__ Incontinence
__ Kidney Stones
__ Kidney Problems
__ UTI
__ Dialysis

Glands
__ Excessive Thirst
__ Frequent Urination
__ Diabetes
__ Always Hot/Cold
__ Thyroid problems
__ Swelling

Blood
__ Anemia
__ Easy Bruise/Bleeding
__ Clotting Disorders
__ Blood Transfusion

Neurological
__ Headaches
__ Migraines
__ Dizziness
__ Vertigo
__ Weakness
__ Change in Sensation
__ Epilepsy
__ Stroke
__ Concussion

Skeletal
__ Arthritis
__ Osteoporosis
__ Broken Bones
__ Painful Joints
__ Sports Injury

Psychiatric
__ Drug/Alcohol Abuse
__ Depression
__ Anxiety
__ Phobias

Male Reproductive
__ Erectile Dysfunction
__ Prostate Problems
__ Dribbling Urine
__ Low Testosterone
__ Infections/STDs
__ Discharge
__ Pain in genitals

Female Reproductive
Last cycle: __________
__ Pregnancies #_____
__ Pain/Discharge
__ Yeast Infections
__ Birth Control or Hormone Replacement
__ Irregular Cycles
__ Post-Menopause

Personal History

Smoking: □ Never □ Previous □ Current ___ packs/day for____ years, Start year:_____ End Year:______
Desire to Quit Level (No desire) 0 1 2 3 4 5 6 7 8 9 10 (Process started)
Surgeries (list year): □ C-section ____ □ Hysterectomy ____ □ Joint Replacement ____ □ Knee Repair ____
□ Shoulder Repair____ □ Spinal Fusion ____ □ Spinal Discectomy ____ □ Other: ____________________________

Alcoholic Beverages: □ Never □ Occasionally/Socially □ Regularly (1-2 servings/week) □ Daily
Coffee □ Never □ Rarely □ Weekly □ Daily
Soda: Regular or Diet □ Never □ Rarely □ Weekly □ Daily
Artificial Sweetener: □ Never □ Rarely (1-2 per month) □ Weekly (1-2 servings/week) □ Daily
Water intake:(glasses/day) □ 1 or less □ 2-4 □ 4-6 □ 6-8
Sleep Habits: □ Poor □ Trouble falling asleep □Trouble staying asleep □ Well Rested
Pain Reliever Use (Type: _________________) □ Never □ Rarely □ Weekly □ Daily
Recreational Drug Use (Type:_____________) □ Never □ Rarely □ Weekly □ Daily
Diet: □ Fruits/Vegetables □ Meat □Processed/Packaged Foods □ Fast Food □ Infrequent Meals
Health Eating Ranking: VERY UNHEALTHY 0 1 2 3 4 5 6 7 8 9 10 VERY HEALTHY
Exercise: (Day/week) □ Never □ 1-2 days/week □ 3-4 days/week □ 5-7 days/week
Physical Stress Level: NO STRESS 0 1 2 3 4 5 6 7 8 9 10 EXTREMELY STRESSED
Emotional Stress Level: NO STRESS 0 1 2 3 4 5 6 7 8 9 10 EXTREMELY STRESSED
Major Stressors (please list 2-3): ____
Things to Improve: ____
Other Health Goals: ____
Rate your overall health right now: □ Excellent □ Very Good □ Good □ Fair □ Poor
Are you satisfied with your overall health? *Yes No* ***Do you desire to lose weight or eat healthier?*** *Yes No*

Reason for visit: ____ Date began: ____/_____/______

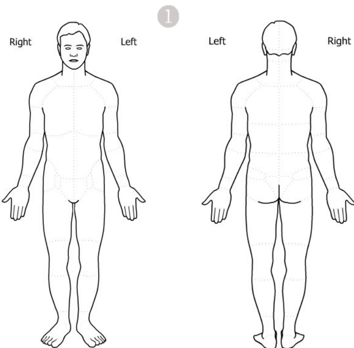
Is this visit a result of an accident (auto, work)? YES or NO Are you currently in litigation for the claim? YES or NO

Frequency: □ Constant (76-100% of the time) □ Frequent (51-75%) □ Intermittent (comes & goes) (26-50%) □ Rare (0-25%)

Have you seen any other providers for this problem? □No □ Yes, Explain: Who/Where:______________________

When: ________________________Treatment:____

□ X-ray □ MRI/CT □ Bone Density Exam Date: ____/____/_____ Facility: ____________ Body part: ____________________



CIRCLE area of discomfort and NUMBER that area
Mark XXX for any radiation or movement of discomfort

No pain ------------------------------------ Severe pain

Area 1: Discomfort Area:_______________________ 0 1 2 3 4 5 6 7 8 9 10

Area 2: Discomfort Area:_______________________ 0 1 2 3 4 5 6 7 8 9 10

Area 3: Discomfort Area: ______________________ 0 1 2 3 4 5 6 7 8 9 10

CONSENT TO TREATMENT

I HEREBY REQUEST AND CONSENT to performance of chiropractic and acupuncture procedures, including but not limited to various modes of physical medicine, therapies, joint manipulation, needling, diagnostic tests, including radiographic x-rays, on me (or the child/patient named below for which I am legally responsible) by the licensed physician(s) and/or other healthcare providers who are now or in the future employed by the office listed above, as deemed necessary. The patient may refuse treatment at any time. I CERTIFY that all information provided to this office is true and correct, to the best of my knowledge, and will have the opportunity to discuss the nature of my case, including treatment, procedures and other options. I understand that results are not guaranteed. I understand and am informed that in the applicable methods of treatment (chiropractic, acupuncture) there are some risks, including fracture, disc injuries, strokes, dislocations, sprains, pneumothorax and infections. I do not expect the physician(s) or other provider(s) to be able to anticipate and explain all the risks and complications, and I wish to rely upon the physician(s) or other provider(s) judgment during the course of the treatment or procedure, given the facts known then to him or her, acting in my best interest. I HAVE READ, or have had read to me, the above consent, and have been offered the amendment document “Informed Consent”. I have had an opportunity to ask questions about its content. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment. ________ INITIALS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the Active Family & Sports Chiropractic PLLC (“AFSC”) “Notice of Privacy Practices” This notice describes how AFSC may use and disclose my protected health information, certain restrictions on the use and disclosure of that information and rights I may have regarding my protected health information. ________ INITIALS

RIGHT TO SUBMIT BILLING

Active Family & Sports Chiropractic PLLC will file claims with your insurance company as a courtesy to you. You will be responsible for your deductible and/or co-payments at the time of treatment. If you insurance company does not pay as anticipated, you accept full responsibility for the amount billed this practice, as soon as we/you are aware of the denial. This practice will attempt payment plans suited to each patient’s individual needs. Ultimately, patients are responsible for all costs for services rendered, legal fees, and collection agency fees. ________ INITIALS

____
PRINTED NAME OF PATIENT

____ ____________________
PATIENT OR GUARDIAN SIGNATURE DATE