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

Demographics

□ Female
Name: _____ Birthday: ____/____/____ SS#: ____-____-_____ □ Male
Address: _____City, State, Zip:_____
Cell #: (_____)_____Home #: (_____)_____Work #: (_____)_____
Email_____ - Used for Online Portal, Check-in, Appointment reminders, Announcements
Contact Preference: Check if: □ CELL □ HOME □ WORK □ EMAIL EMPLOYER:_____
Race: □ White □ Black/AA □ Hispanic/Latino □ Multi/Other:_____ Preferred language if not English:_____
Emergency Contact: _____Relation:_____ Phone: (_____)_____
Primary Care Physician: _____ Last exam or visit: ____/____/____Reason:_____

Insurance

Insurance:_____□ Check if policy holder is yourself and skip to the next section
Policy Holder Name: _____ Policy Holder DOB: ____/____/____

Medical 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: _____
Major Hospitalization/Infections/Trauma: _____

Review of Systems

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

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

-OVER-

Nutritional History

Water	□ Seldom (less 1 glass/day)	□ Some (2-3 glasses)	□ Regularly (4-6 glasses)	□ Exclusive (6+glasses)
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
Dairy	□ Never	□ Rarely	□ Weekly	□ Daily
Gluten/Grains	□ Never	□ Rarely	□ Weekly	□ Daily

Diet: □ Fruits/Vegetables □ Meat □Processed/Packaged Foods □ Fast Food □ Infrequent Meals

Current Medications: _____

Medication Allergies: _____ Reaction: _____

Current Supplements/OTC: _____

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.

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.

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.

_____

PRINTED NAME OF PATIENT

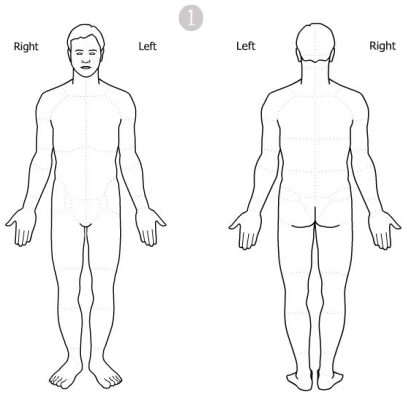
_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

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

Current Complaints

Name: _____ Date: _____



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

Complaint 1: _____ Date began: ____/_____/_____
Describe pain/complaint: _____
Frequency: □ Constant (76-100% of the time) □ Frequent (51-75%) □ Intermittent (comes & goes) (26-50%) □ Rare (0-25%)
Worse: □ Morning □ Afternoon □ Evening □ Night □ No different
What makes it worse? _____
What makes it better? _____
Affected ability to: _____
Other provider seen -Who:_____ Where:_____
When: _____Treatment:_____
□ X-ray □ MRI/CT □ Bone Density Exam Date: ____/____/_____ Facility: _____ Body part: _____

Complaint 2: _____ Date began: ____/_____/_____
Describe pain/complaint: _____
Frequency: □ Constant (76-100% of the time) □ Frequent (51-75%) □ Intermittent (comes & goes) (26-50%) □ Rare (0-25%)
Worse: □ Morning □ Afternoon □ Evening □ Night □ No different
What makes it worse? _____
What makes it better? _____
Affected ability to: _____
Other provider seen -Who:_____ Where:_____
When: _____Treatment:_____
□ X-ray □ MRI/CT □ Bone Density Exam Date: ____/____/_____ Facility: _____ Body part: _____

Complaint 3: _____ Date began: ____/_____/_____
Describe pain/complaint: _____
Frequency: □ Constant (76-100% of the time) □ Frequent (51-75%) □ Intermittent (comes & goes) (26-50%) □ Rare (0-25%)
Worse: □ Morning □ Afternoon □ Evening □ Night □ No different
What makes it worse? _____
What makes it better? _____
Affected ability to: _____
Other provider seen -Who:_____ Where:_____
When: _____Treatment:_____
□ X-ray □ MRI/CT □ Bone Density Exam Date: ____/____/_____ Facility: _____ Body part: _____