Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member.
Thank you and welcome to HealthSource!

Patient Information

First Name: _____ Middle _____ Last _____ Gender: __M __ F

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Birthdate: _____ Age: _____

Marital Status: __ S __ M __ W __ D Job Title: _____ Work Phone: _____

Spouse Name: _____ Birthdate: _____

Children: Names and Ages:_____

Insurance Information

Name of person on the insurance card: _____ DOB:_____

Name of employer: _____

Employer phone number: _____ City: _____

Person responsible for this account: _____

Additional Information

In case of emergency, whom should we contact? _____

Relation to patient: _____ Phone Number: _____

Family Physician: _____

May we send your Family Physician updates on your progress? _____Yes _____ No

What is your primary complaint? _____

_____

Is this worker's compensation? _____ Is this personal injury? _____

ACTIVE SPINE & SPORT
THERAPY

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____
Parent or Guardian: _____ Signature:_____ Date: _____
Witness Name: Philicia Black Signature:_____ Date: _____

Acknowledgement of Notice of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that this Notice is available by request.

_____

Name of Patient or Legal Representative *Date*

_____

Signature of Patient or Legal Representative *Date*

Facility Use Only

- ❑ Patient has been provided Acknowledgement of Notice of Privacy Practices and has refused to sign.

_____

Authorized Staff Signature *Date*

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed amounts for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLES AT THE TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT'S/GUARDIAN'S SIGNATURE INSURED'S SIGNATURE

INSURANCE COMPANY NAME DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer or my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee healthcare plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered and valid as the original. I have read and fully understand this agreement.

PATIENT'S/GUARDIAN'S SIGNATURE DATE

CANCELLATIONS/LATE ARRIVALS/NO-SHOWS

Our office doesn't accept cancellations but we will gladly reschedule your appointment. Your healing progress is based on consistent visits.

Cancellations - Our office policy requires a 24-hour notice for appointment cancellations or rescheduling. We typically have a waiting list of patients who would like to see the Doctor or Physical Therapist. If you cannot make your appointment, please extend the office and other patients the courtesy of giving ample notice so that someone on the waiting list may be seen during that time.

Late Arrivals - If you arrive more than 10 minutes late for your appointment, expect to be rescheduled or to wait for an open spot in that day's schedule. Nobody likes to wait any longer than they have to at the doctor's office. It only takes one person being a few minutes late to cause everyone to have to wait that day.

No-shows - We understand that things do come up and we will try to be as accommodating as possible. But please be aware that a $25 fee will be assessed for no-shows and cancellations without a 24-hour notice.

We recognize that your time is valuable-this will help us stay on schedule and minimize the time you wait for your appointment.

I understand and accept this policy.

_____ _____

Patient Signature **Date**

ACTIVE SPINE & SPORT
THERAPY

NAME: _____ **DATE:** _____ **PHYSICIAN:** _____

Have you RECENTLY noted any of the following (check all that apply)?

□changes in appetite
□ changes in bowel or bladder function
□ difficulty maintaining balance while walking
□ difficulty swallowing
□ dizziness/lightheadedness
□fever/chills/sweats
□ headaches
□ nausea/vomiting
□ pain at night
□ shortness of breath
□ weakness/fatigue
□ weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

□ anemia
□ asthma
□ cancer (type)_____
□ chemical dependency (i.e., alcoholism)
□ depression
□ diabetes
□ pacemaker inserted
□ other_____
□ heart disease
□ high blood pressure
□kidney/liver problems
□ lung problems
□ multiple sclerosis
□ osteoporosis
□HIV
□ Parkinson's disease
□ rheumatoid arthritis
□stomach ulcers
□ stroke
□ thyroid problems
□ epilepsy
□arthritis

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you smoke? YES NO _____ pack/day
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list current medications (QUATINITY& FREQUENCY):
1)_____2)_____ 3)_____
4)_____5)_____6)_____
Are you currently taking blood thinning or anticoagulant medications for any medical conditions? YES NO
ALLERGIES: _____
Are you latex sensitive? YES NO

PLEASE LIST PAST SURGERIES:
1. _____ Year_____ 2. _____ Year_____
3. _____ Year_____ 4. _____ Year_____
5. _____ Year_____ 6. _____ Year_____

HEIGHT_____ **WEIGHT**_____

FOR DIABETIC PATIENTS only: **SHOE SIZE AND WIDTH**_____
□Hammer toes □Blister/ callus □Bunions □Corns
□Xerosis (dry, rough, cracking) □Ingrown Nails

Patient Signature: _____ **Date:** _____
(office use only) PT initials_____ Date_____

ACTIVE SPINE & SPORT THERAPY

NAME_____

DATE_____

What is your main complaint or injury? _____

Date of Onset_____ **How did it Occur?** _____

Date of Surgery_____**Type**_____

Occupation_____

Working:	Full-time	Part-time	Light Duty	Not working		
Job Requires:	Sitting	Standing	Bending	Walking	Lifting	Sitting
Physical Requirements:		Sedentary	Light	Moderate	Heavy	Very Heavy

Please circle how you would best describe your pain or symptoms:

Constant Intermittent Sharp Dull/ Ache Burning Throbbing Stabbing Pins/ Needles Shooting Tingling/ Numb Tight Pulling Other_____

Pain Level: SEVERITY On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

Pain at LOWEST

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Pain CURRENTLY:

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Pain at WORST:

0 1 2 3 4 5 6 7 8 9 10

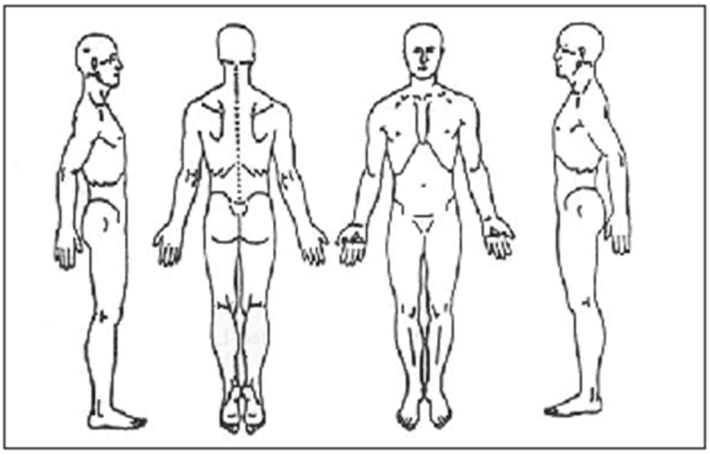
No pain Worst pain

BODY CHART:

X Sharp stabbing pain **..... Numb/ Tingling**

O Dull achy pain **//// Throbbing**

==== Burning



What aggravates the pain/symptom?

_____Sneezing	_____Lifting	_____Exercising	_____Looking up/down	_____Walking
_____Coughing	_____Sitting	_____Stooping	_____Looking side/side	_____Standing
_____Stress	_____Driving	_____Getting out of bed	_____ Repetitive movement	_____Pulling
_____Pushing	_____Carrying	_____Straining at BM	_____ Getting in/out of car	_____ Stairs

Other:_____

What relieves this pain/symptom? _____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down _____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice _____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

List 1 (one) important activity you are unable to perform as a result of your pain or symptoms:

_____.

What is your goal for physical therapy?_____.

Patient Signature:_____ **Date:**_____

(office use only) PT initials_____ Date_____