Active Lifestyle Clinic | KEEPING YOU ACTIVE FOR LIFE

Chiropractic Case History

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ _ State:_____ Zip:_____

E-mail Address:_____Fax #_____ Cell Phone:_____

How do you prefer to be contacted by us? Text or Email? If Text: Which carrier do you use? _____

Birth Date:_____ Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse Name:_____ # children?_____ Names and Ages children:_____

_____

Emergency Contact:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case**:**

❒ Health Insurance ❒ Worker's Compensation ❒ Medicare ❒ Auto Accident
❒ Medical Savings Account & Flex Plans ❒ Other _____

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

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INFORMED CONSENT

PATIENT NAME _____

Chiropractic Care:
I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as " Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain, rare complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, strains and dislocations, costovertebral strains and separation. Extremely rare complications include, but are not limited to stroke or fracture. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

Physical Therapy:
I understand that the exercises and myofascial release I receive is provided for relief of muscular tension and pain. If I experience any discomfort, I will immediately inform the therapist so that the pressure can be adjusted to my level of comfort. I agree to keep the therapist updated to any changes in my health and understand that there shall be no liability on the therapist's part if I fail to do so.

Naturopathic Care:
I understand that all injection treatments are accompanied by possible risks. Risks include bruising, temporary increase in pain, inflammation, infection, allergic reaction, numbness, weakness or paralysis, spinal headache, lung puncture or death as a result of, or in relation to the injections.

Injections may include nerve blocks, Intravenous therapies, trigger blocks, intramuscular injections, scar therapy, joint/tendon/ligament injections, or prolotherapy.

I understand that insurance reimbursement for injections varies and that prolotherapy may be considered investigational or experimental by some carriers or Medicare.

I am aware of all of the above mentioned complications for each therapy I may receive, and in order to minimize their occurrence I will take precautions. I have been given the opportunity to discuss the nature and purpose of all treatments in this office, alternative methods of treatment, risks and complications associated with them. I acknowledge that all my questions have been answered to my satisfaction and that I have been further told that any additional questions I may have will be answered.

If my child is a minor, I have given consent for him/her to receive the necessary care in this clinic according to this consent.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)