



## Welcome

### Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone#: \_\_\_\_\_ Work/cell phone#: \_\_\_\_\_  
Sex: M or F Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
How did you hear about our practice?: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_  
What is your Chief Complaint? \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_ City: \_\_\_\_\_

### Accident Information

Is this due to an auto accident or work accident: Yes No If Yes, what type? \_\_\_\_\_  
Has it been reported: Yes No If Yes, what type? \_\_\_\_\_

### Financial Information

Responsible Party's name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_  
Relationship to patient (if other than self): \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

### Assignment and Release

I certify that I (or my dependent) have insurance coverage with the above insurance and I authorize, request, and assign my insurance company to pay directly to the physician/medical practice insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

### Office Policy

The goal of Active Life Institute is to provide high quality chiropractic and rehabilitative care to our clients. In order to do so, we ask that you please keep the following in mind when treating with our office.

1. Appointments cancelled within 24 hours are subject to a \$25.00 fee.
2. Any patient showing up late for their appointment without prior notice will be assessed a \$25.00 fee for the providers time and will be asked to wait for the next available appointment time.
3. All payments for services are due at the time of service in full unless payment arrangements have been made with the office manager.
4. Any account with a balance past due exceeding 30 days will be assessed interest in the amount of 1.5% monthly.
5. Any outstanding balance that remains unpaid will be reporting to credit agencies.
6. All clients are responsible for making up cancelled appointments within 7 days.
7. Due to our open environment if you require private space for any discussion with our providers, please ask.

If at any time you have questions regarding our office or privacy policies, please ask to speak with our office manager.

By signing below, I am acknowledging both receipt of, and understanding of the policies listed above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Health History

Are you currently under medical care? If yes, please explain \_\_\_\_\_

Please list any drugs/medications that you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

How often do you exercise:      5-7 times/week                  3-5 times/week                  1-2 times/week                  None

What is your daily/weekly intake of the following:

Caffeine: \_\_\_\_\_ cups/day      Alcohol: \_\_\_\_\_ drinks/week      Water: \_\_\_\_\_ cups/day

Do you smoke?    Yes    No      If yes, how many packs per day?: \_\_\_\_\_

Please indicate if you are currently experiencing any of the following conditions:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothering Eyes | <input type="checkbox"/> Nausea              |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression           | <input type="checkbox"/> Fever               |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Loss of Memory      |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension              | <input type="checkbox"/> Cold Feet           |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats          | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain           | <input type="checkbox"/> Chest Pain          |
| <input type="checkbox"/> Sudden Weight Loss  | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Jaw Problems        |

Please indicate if you have ever had or currently have any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV      | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Rheumatoid Care    |
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> Allergy       | <input type="checkbox"/> Herniated Disc   | <input type="checkbox"/> Drug Dependency    | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Miscarriage        |
| <input type="checkbox"/> Anorexia      | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Measles          | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Migraines        | <input type="checkbox"/> Typhoid Fever      | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gout             | <input type="checkbox"/> Prosthesis         | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> Bulimia       | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Prostate Problems  | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Stroke           | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Parkinson's   | <input type="checkbox"/> Thyroid Problems |   |   |

### Neurological and Vascular Questionnaire

- |  |     |    |
|--|-----|----|
| 1. Do you suffer from neck pain with pain in your shoulders, arms, and/or hands?         | Yes | No |
| 2. Do you have weakness; numbness, and/or burning in your shoulders, arms, and/or hands? | Yes | No |
| 3. Do you have reduced feeling (sensation) and/or swelling in your hands and/or arm?     | Yes | No |
| 4. Do you suffer from back pain with pain in your buttocks, legs, and/or feet?           | Yes | No |
| 5. Do you suffer from a loss of handgrip strength?                                       | Yes | No |
| 6. Do you have weakness, numbness, and or burning in your buttocks, legs, and/or feet?   | Yes | No |
| 7. Do you have reduced feeling (sensation) and/or swelling in your legs and/or feet?     | Yes | No |
| 8. Do you suffer from cold hands and/or feet?  | Yes | No |
| 9. Do you suffer from headaches, dizziness, and/or memory loss?                          | Yes | No |
| 10. Do you have difficulty maintaining your balance, vertigo and/or blurred vision?      | Yes | No |
| 11. Do you suffer from a reduced hearing or ringing in your ears?                        | Yes | No |
| 12. Do you have bladder and/or bowel control problems on a regular basis?                | Yes | No |

If you answered yes to any of the above questions, please explain \_\_\_\_\_

\_\_\_\_\_

**Consent to Care**

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing statement.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**X-Ray Consent**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition.

I request that x-ray films not be taken because: \_\_\_\_\_

Yes, I am definitely pregnant.

No, I am definitely not pregnant.

There is a possibility that I may be pregnant at this time.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Privacy Practice Acknowledgement**

I hereby acknowledge that Notice of Privacy Practices for Active Life Institute regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized, and disclosed by the clinic and my respective rights contained there in. I also understand that the notice posted is subject to change at any time. I am aware that I may obtain a current copy of this notice at any time by contacting the office directly at:

**Active Life Institute**

1220 Iroquois Drive, Suite 180  
Naperville, IL 60563  
(630) 717-8575

or

409 S. Main Street  
Seneca, IL 61360  
(815) 357-1071

My signature herein below constitutes full acknowledgement of the privacy practices for Active Life Institute.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by patients legal representative, please state the relation to the patient.

\_\_\_\_\_