Chiropractic for the Sport of Living

Thank you for selecting ActiveSpine and its providers for your healthcare needs. We are honored to have your trust in your care. It is our desire to provide you with comprehensive care in a family atmosphere. We are here to answer your questions about your health, medical conditions and treatment.

We are proud to be a referral based clinic. Who may we thank for referring you to our clinic?

_____

On the next few pages, we will be asking a variety of questions to best determine the most appropriate diagnosis and course of treatment. This information is critical to determining what treatment you will best respond to. Please fill out the questionnaire to the best of your ability.

Would you like us to send your medical records to your Medical Physician?

If so, Name: _____ Specialty? _____

Medical Group:_____

Release of Medical Records Signature: _____

6209 S Old Village Place, Sioux Falls, SD 57108 (605) 271-8277 Beactiveinc.com

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____/_____/_____Age:_____ Cell Phone: _____ Work Phone:_____

Email: _____

Case Type: Auto Injury WorkComp SelfPay Insurance Co: _____

Primary Care Physician: _____ Med Group: _____

Yes or No To best suit your care, do you want us to send your Primary Care Physician documentation for their records?

Financial

A patient's insurance policy is a contract between the patient and his or her insurance company. However, all charges, regardless of the insurance coverage, are the patient's responsitiblity and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, ActiveSpine bills the insurance company and makes every effort to ensure that claims are promptly and correctly processed. Patient co-pays are due at the time of service and any remaining payment is due within 30 days of receiving the first bill from ActiveSpine. If the patient has a high deductible insurance policy that has not been met, a charge of $50 will be due at the time of service and will be used towards the patient's account. Any expense toward collection of outstanding balance will be added to the patient total outstanding amount.

Copay:	A copay is a fixed amount you pay for a health care service, due when you receive the service.
Co-Insurance	Coinsurance is your share of the costs of a health care service. It's figured as a percentage of the amount insurance allows to be charged for services.
Deductable:	A deductible is the amount you pay for health care services PRIOR to when your health insurance begins to pay.
PayPal:	In efforts to conserve paper, I agree to recieve emailed statements and, for patient convience, to pay my responsibility for services provided.

I have reviewed ActiveSpine's Financial Responsibility Policy and agree to its terms

Signature: _____ **Date:** _____

Informed Consent

Consent for Treatment

Every medical procedure, no matter how simple or complicated, carries risk. The providers at ActiveSpine do our best to minimize the risk of adverse effects. Please review ActiveSpine's Informed Consent form before signing below.

Treatment of a minor

Yes or No As parent and/or guardian of the patient, I give the physician permission to treat my child when he/she accompanied to the clinic by another adult, such as grandparents, guardian, or of-age sibling or caretaker.

I have reviewed ActiveSpine's Consent Policy and agree to its terms

Signature: _____ **Date:** _____

HIPPA

The providers and staff at ActiveSpine do our absolute best to protect your personal health information. Our specific office policy is described in our Notice of Privacy Practices and is provided for your review. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

I have reviewed ActiveSpine's Notice of Privacy Practices and agree to its terms

Signature: _____ **Date:** _____

VERIFICATION

I verify that the information that has been provided is accurate and up to date to the best of my knowledge

Signature: _____ **Date:** _____

Active SPINE

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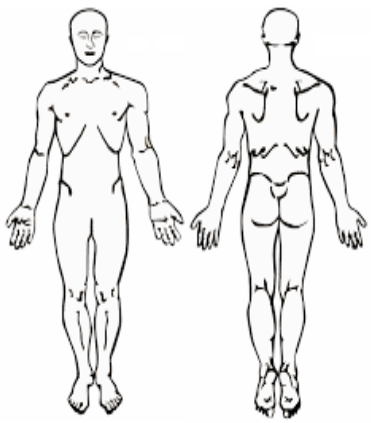
First Name: _____ Last Name: _____

Height: _____ Weight: _____lbs BP / Pulse: bpm

HISTORY OF PRESENT COMPLAINT: Fill in the blank and (circle that apply)

MARK LOCATION OF SYMPTOMS



1. Chief Complaint: _____

2. Cause of your Complaints: _____

3. Duration of Complaint: _____(many) days weeks months years
   OR Specific Date of Injury: _____

SEVERITY AND QUALITY OF COMPLAINT (circle that apply)

4. Severity of complaint: Mild Mild to Moderate Moderate Moderate to Severe Severe
   OR Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 (0 no pain- 10 unbearable)
5. Type of Complaint: Dull Ache Stiff Sharp Burning
   Sharp at Times Sharp w Movement Other: _____
6. Radicular complaints: Non Radiating OR Radiates to: _____

TIMING OF COMPLAINT (circle that apply)

7. Timing of Complaint: Morning Evening Progresses throughout day Other: _____
8. Frequency of Complaint 0-24% 25-49% 50-74% 75-100% of the day
9. Change in complaint since pain started: Getting Better Getting Worse No Change

What are the Improving and Aggrevating Factors (circle that apply)

10. Symptoms improved by: Rest Stretches Movement Ice Heat OTC Rx Injections
    Other: _____
11. Symptom aggravated by: Walking Standing Sit to stand Lifting Running Swimming Reaching Sleeping
    Overhead Act Sitting Other: _____

12. Are there Associated Signs/Symptoms of Current Complaint (circle that apply)

Denies All Fever/Flu Ongoing Dizziness Difficulty Breathing Chest Pain Vision Changes Auditory Changes
Bowel Changes Bladder Changes Excessive Fatigue Urinary Pain Saddle Numbness Unexplained Wt Loss

Headaches Yes or No If yes, Location: _____ Severity: _____ Duration: _____
Associated Symptom with Headaches:

Has there been Previous Episodes and Care

13. Other Physicians Seen for Current Complaint?	Yes or No	Result of Treatment
MD: _____		Treatment Provided: _____
DC: _____		Treatment Provided: _____
PT: _____		Treatment Provided: _____

14. Recent Diagnostic Testing: Yes No Date: _____
    If yes, what type of Test: Xray MRI CT Bone Scan Other: _____
    Results of Testing: _____

15. Previous Episodes of Current Complaint: Yes No
    If so, when: _____
    Please Discribe: _____

16. Other Pertinant Information
    related to your condition: _____

SIGNATURE: _____ DATE: _____

Review	**Musculoskeletal**	**Neurological**	**Head & ENT**	**Cardiovascular**	**Respiratory**
Of Systems	Denies All	Denies All	Denies All	Denies All	Denies All
	RA	Seizures	Blurred Vision	Aneurysm	Asthma
	Osteoarthritis	Migraines	Double Vision	Stroke	Bronchitis
	Gout	TIA	Cataracts	TIA	COPD
	Osteoporosis	Arnold Chiari	Glaucoma	Angina	Pneumonia
	Osteopenia	Depression	Corrective Lens	Atherosclerosis	SOB
	Implants	Dizziness	Hearing aids	DVT	Apnea
	Fusion	Memory	Loss of Hearing	Hypertension	Hay Fever
	Pins/Screws	Loss of Smell	Deafness	High cholesterol	TB
Other:	_____	_____	_____	_____	_____
	GI	**GU**	**Endocrine**	**Derm/Hemo**	**Allergy**
	Denies All	Denies All	Denies All	Denies All	Denies All
	Abdominal pain	Hernia	Goiter	Skin Cancer	Enviro
	Cirrhosis	Incontinence	Hyperlipidemia	Easy Bruising	Mold
	GERD	Kidney stones	Thyroid Issue	Psoriasis	Latex
	Gallbladder	UTI	ParaThyroid Issue	Eczema	Nuts
	Hepatitis	Blood	Diabetes	Hair Loss	Dairy
	Ulcer	Increase Freq	Excess Thirst	Rash	Adhesive
	Blood	Urgency	Pancreas	Nail Change	Gluten
	Changes	ED	Cushings	Hair Change	Rx:
Other:	_____	_____	_____	_____	_____
Past & Current Health History					
	Surgery:				
	Medications:				
	Illnesses:				
	Trauma:				
Immediate Family History					
	Denies All	Unsure	Diabetes	Cancer	Hypertension
	Bleeding Disorder	Depression	Heart Disease	HBP	Kidney Disease
	Neuro Disorder	Congenital Issue	AIDS/HIV	Alzheimer's	Arthritis
	Liver Disease	MS	Osteoporosis	Parkinsons	Rheumatoid
Social History					
	Employment:	FullTime PartTime HomeMaker Student Retired Modified d/t Injury			
	Work Activity:	Mostly Sitting	Mostly Standing	Mostly Walking	Mix
		Sedentary	Light Labor	Moderate Labor	Heavy Labor
	Social Habits:	Tobacco Use	Past	Present	Never
		Alcohol	None	Social	Light Moderate
		Caffeine Per Day	None	Mild to Moderate	Moderate+
		Diet	Unrestricted	Restricted	
	Exercise:	None	Modified D/T Injury	Frequent	Daily
	Type of Exercise:				