ProActive
HEALTH & WELLNESS, LLC

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GENTLE CHIROPRACTIC CARE,
MASSAGE THERAPY & NUTRITION

Confidential Patient Information

Date _____

First Name: _____ Last Name: _____ Initial _____

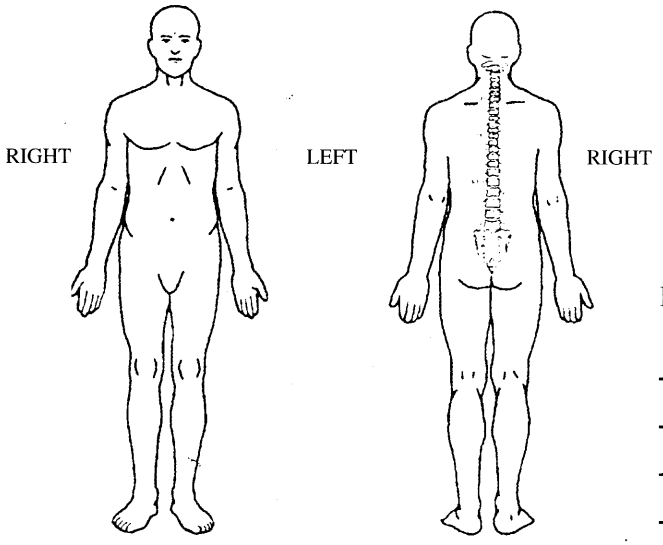
Major Complaint Information

What is your major complaint(s)? _____

_____

When did this symptom(s) begin? _____

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)



Pain Index

B Burning
S Sharp / Stabbing

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "B8" on the neck of the illustration.

It this is an injury, describe what happened:

_____
_____
_____
_____

On a scale of 1-10, how do you feel now? (1 being the best, 10 being the worst)

1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ❍ Yes ❍ No When? _____

Theses symptoms developed from? ❍ Auto Accident ❍ Work-Related ❍ Other: _____

Have you reported this to your: insurance company ❍ Yes ❍ No employer ❍ Yes ❍ No

What aggravates this condition? _____

What decreases the symptoms / pain? _____

Have you seen another doctor for this condition? ❍ Yes ❍ No Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? ❍ Yes ❍ No If so, how many times do you wake up in pain per night? _____

In what position do you sleep? ❍ Back ❍ Side ❍ Stomach

Do you sleep with a pillow? ❍ Yes ❍ No How many? _____

Does heat affect the pain? ❍ Yes ❍ No If so, how? _____

Does cold affect the pain? ❍ Yes ❍ No If so, how? _____

Do you wear a heel lift? ❍ Yes ❍ No If so, which side? ❍ Right ❍ Left

Does it cause pain to cough, grunt, or sneeze? ❍ Yes ❍ No If so, where? _____

Check those activities below during which you experience difficulty or pain:

❍ Lying on back	❍ Getting in/out of car	❍ Sleeping	❍ Stooping	❍ Standing for periods
❍ Lying on side with knees bent	❍ Gripping	❍ Pushing	❍ Sitting	over one hour
❍ Turning over in bed	❍ Climbing	❍ Pulling	❍ Bending forward	❍ Sneezing
❍ Lying flat on stomach	❍ Dressing Self	❍ Reaching	❍ Bending backward	❍ Coughing
	❍ Sexual Activity	❍ Kneeling	❍ Walking	❍ Other:_____

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Headaches

Do you have a family history of headaches? ❍ Yes ❍ No Do you get headaches? ❍ Yes ❍ No Frequency _____

Do you experience the following along with your headaches: Pain or cracking in your jaw? ❍ Yes ❍ No

Abnormal blood pressure? ❍ Yes ❍ No ❍ High ❍ Low Nausea, Vomiting or Visual disturbances? ❍ Yes ❍ No

When was your last eye exam by a doctor? ❍ 1 - 6 months ❍ 6 - 12 months ❍ 1 - 2 years ❍ over 2 years Results:_____

Lower Back Pain

Do you ever experience ripping or tearing sensations in you back? ❍ Yes ❍ No If so, where: _____

Does pain radiate to the abdomen? ❍ Yes ❍ No

Do you ever have impairment of bowel or urinary function? ❍ Yes ❍ No Explain: _____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) ❍ Hearing ❍ Vision ❍ Balance ❍ Cause ringing in your ears

Do you hear grating sounds? ❍ Yes ❍ No Do you feel pressure or pain behind your eyes? ❍ Yes ❍ No

Do you feel ripping or tearing? ❍ Yes ❍ No Where: _____

Do you have difficulty lifting or turning your head? ❍ Yes ❍ No If so, in which direction? ❍ Right ❍ Left ❍ Up ❍ Down

If female, are you pregnant? ❍ Yes ❍ No ❍ Not Sure If yes, what is your due date?: _____

List all medications you are taking now, including over the counter medication. _____

_____

Are you allergic to any medications? ❍ Yes ❍ No ❍ Not Sure Please list: _____

_____

Have you ever had any surgeries or hospitalizations? ❍ Yes ❍ No Please list:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months? ❍ Yes ❍ No When?: _____

Have you ever been seen by a chiropractor before? ❍ Yes ❍ No Please list:

Name of Chiropractor:	Dates:	Name of Chiropractor:	Dates:
_____	_____	_____	_____

Do you have a family physician? ❍ Yes ❍ No Name of physician: _____ Phone: _____

Address: _____

City/State/Zip: _____

Additional Complaints

Please check all additional complaints that you have at this time:

- ❍ Headache
- ❍ Loss of Concentration
- ❍ Eyes Sensitive to Light
- ❍ Memory Loss
- ❍ Heavy Feeling of Head
- ❍ Dizziness
- ❍ Ringing in Ears
- ❍ Loss of Balance
- ❍ Loss of Smell
- ❍ Loss of Taste
- ❍ Pain Behind Eyes
- ❍ Fainting
- ❍ Palpitation
- ❍ Neck Pain
- ❍ Neck Stiffness
- ❍ Neck Motion Restricted
- ❍ Upper Back Pain / Stiffness
- ❍ Mid Back Pain / Stiffness
- ❍ Lower Back Pain / Stiffness
- ❍ Right / Left Shoulder Pain
- ❍ Right / Left Arm Pain
- ❍ Right / Left Leg Pain
- ❍ Pins & Needles Arms / Legs
- ❍ Vision Problems
- ❍ Sinus Trouble
- ❍ Nervousness
- ❍ Chest Pain
- ❍ Shortness of Breath
- ❍ Loss of Consciousness
- ❍ Irritable
- ❍ Anxiety
- ❍ Depression
- ❍ Insomnia
- ❍ Fatigue
- ❍ Flushed Face
- ❍ Excess Perspiration
- ❍ Digestive Trouble
- ❍ Nausea
- ❍ Vomiting
- ❍ Diarrhea
- ❍ Constipation
- ❍ Cold Hands
- ❍ Cold Feet
- ❍ Jaw pain
- ❍ Cancer
- ❍ Hypertension
- ❍ Diabetes
- ❍ Hepatitis
- ❍ Convulsions
- ❍ Allergies (Please List)

  _____
  _____
  _____
  _____
- ❍ Anemia
- ❍ Heart Disease
- ❍ Arthritis
- ❍ HIV (Aids)
- ❍ Other (Please List)

  _____
  _____
  _____

Please Specify Location:

- ❍ Numbness _____
- ❍ Swelling _____
- ❍ Cuts _____
- ❍ Bleeding _____
- ❍ Broken Bones _____
- ❍ Bruising _____

Do you have, or have you ever had, any diseases or medical problems not listed? ❍ Yes ❍ No If so, please list: _____

_____

Any additional information you would like the doctor to know about before beginning care at ProActive: _____

_____

Emergency Contact

Name: _____ Relation: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Address: _____

City / State / Zip: _____

Insurance Information

Insurance Company: _____ Phone # _____

Address: _____

City / State / Zip: _____

Insured's Name: _____ *Insured's SS# - provided in person* Group # _____

Insured's Birth Date: _____ Insured's Employer: _____

Personal Information

Address: _____

City / State / Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Pager: _____ Email: _____

SS# - provided in person

Birth Date: _____ Age: _____ Sex: ❍ M ❍ F

Please bring your driver's license and Social Security number to your first visit.

Marital Status: ❍ S ❍ M ❍ D ❍ W Spouse's Name: _____ # of Children: _____

Occupation: _____ Employer's Name: _____

Work Address: _____

City / State / Zip: _____

How were you referred to ProActive? _____

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at ProActive to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of ProActive responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkable safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. These are rare, but if it occurs, you should report it to your doctor, or a staff member at ProActive.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature: _____ Date _____

Parent/Legal Guardian Signature: _____ Date _____

Seasonal Address Information

If you reside at a second address during part of the year, please provide the information below:

Second Address: _____

City / State / Zip: _____

Phone: _____

Check months at this address:

○	○	○	○	○	○	○	○	○	○	○	○
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec