

WELCOME To Our Office

PLEASE FILL OUT THIS HEALTH PACKET AS COMPLETELY AS POSSIBLE SO WE CAN BETTER SERVE YOU

Your nervous system is the master system and controller of your body. Health and Wellness are therefore mediated through your system. What makes our office different is that we have a unique and modern approach to supporting and expanding your health by improving how your nervous system performs. The Neurospinal Function Index (NSFi), which is the rating of results of the series of test with the Insight technology that the doctor will have ordered on you, scales from 0-100. The higher the score, the better your NSFi.

Lifestyle stress adversely affects your nervous system and general health. Many times, when people think they have a 'back problem', what they really have is a 'health problem' that is a result of the way they are living.

Please answer the following questions so we may better understand how to help you:

On a scale of 1 to 10 (10 being the most important) how important is your health to you? _____

Do you:

Belong to health club?	Yes	No
Use vitamins?	Yes	No
Watch more than 5 hours of TV a week?	Yes	No
Spend 1 or more hours on a computer daily?	Yes	No
Drink Soda?	Yes	No (Diet or Regular)

What do you do for stress relief? _____

Are there any other health habits that you could share with us? _____

On the graph to the right: Please mark an "X" where you believe your health is and an "O" where you would like it to be.

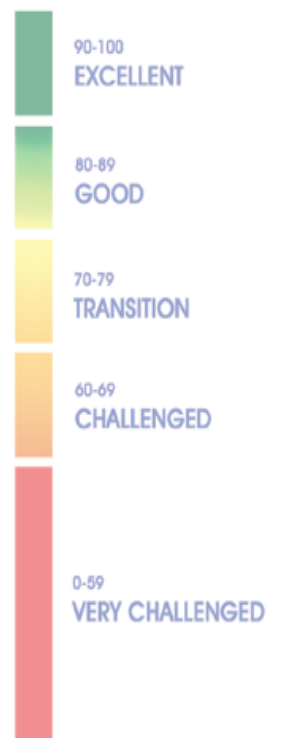
How long do you think it might take you to get where you circled? _____

What things might you need to change to help you reach your goal?

- A.
- B.
- C.
- D.

If we could make recommendations that would not only address your main concerns, but could also help you with improving your overall health, would you like to hear them? Y N

NeuroSpinal
Function
Index (NSFi)



Signature: _____ Date: _____

ABOUT YOU

Today's Date: ___/___/___

Name: _____ What do you prefer to be called? _____ Male Female

Birth date: _____ Age: _____ SS#: _____

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

Home Phone #: _____ Cell Phone: _____ Other: _____

Email: _____ @ _____

Referred By: _____ Employer: _____

Occupation: _____

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

Work Phone: _____ Marital Status: Single Married Divorced Separated Widowed

Emergency Contact: _____ Phone: _____ Relationship: _____

Is this related to an Auto Accident? Y N Is this related to Workers Comp? Y N

Insurance Info: Co. Name: _____ Insured's SS#: _____

Ins. Address: _____ City: _____ State: _____ Zip: _____

Group # (Plan, Local or Policy#): _____ Insured's Name: _____

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

YOUR HEALTH PROFILE

YOUR CHILDHOOD YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Circle all that apply

Did you have any childhood illnesses?	Yes	No	Were you in any car accidents as a child?	Yes	No
Did you have any serious falls as a child?	Yes	No	Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No
Did you play youth sports?	Yes	No	Did you suffer any other traumas? (physical or emotional)	Yes	No
Did you take Medications?	Yes	No	As a child, were you under regular chiropractic care?	Yes	No
Did you have surgery?	Yes	No			
Have you fallen / jumped from a height over three feet?	Yes	No			

Please share any additional information: _____

HEALTH HISTORY (ADULT TO PRESENT)

Do/did you smoke? Yes No
Do/did you drink alcohol? Yes No
Have you been in any accidents? Yes No
Have you had any surgery? Yes No
If yes, list here: _____

Do/did you play adult sports? (Extreme) Yes No

Rate these following as Poor, Good, and Excellent:

Diet: _____ what do you eat? _____

Exercise: _____ When and how long? _____

Sleep: _____ Hours per day? _____

General Health: _____

On a scale of 1 – 10 describe your stress level:

(1 = none / 10 = extreme)

Occupational: _____ Personal: _____

Addressing issues that may have brought you to our office

If you have no symptoms or complaints, and are here for wellness services, please check here: _____ and then skip to Family Health Profile. Otherwise please briefly explain what brought you to our office today: _____

If you are experiencing pain, is it... Sharp Dull Comes and Goes Travels Constant

Since the problem started, it is... About the Same Getting Better Getting Worse

Does this interfere with: Work Sleep Walking Hobbies Leisure Other: _____

What percent of the time does this condition bother you? 0% 25% 50% 75% 100%

How would you rate the level of discomfort on a scale of 0-10 (0= no pain 10= extreme pain)? _____

What aggravates Condition? _____ What offers relief? _____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Other _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff at Active Health Chiropractic to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand that if I am dealing with an attorney, and my case does not settle, or no money is collected, or if my insurance coverage does not cover this type of treatment, I will be billed and take responsibility for all the payments due for the Chiropractic/Massage services I receive. In respect to my appointment I will give a 24 hour notice for cancellations (Chiropractic/Massage) or I will be charged a no show fee of \$25.00 (Massage only).

Massage Therapy:

- I understand that the purpose of massage is for stress reduction, relief from muscular tension, spasm or pain: or for increasing circulation of energy flow. I understand that the massage practitioner does not diagnose illness, disease or any other physical or mental disorder. Nor do they perform spinal manipulation or dispense pharmaceutical products. It has been made clear to me that massage is not a substitute for Chiropractic/physician examination or diagnosis, and that it is recommended that I see a Chiropractor/physician for any ailment that I might have.

Chiropractic and Massage:

- I have completed this information form to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

HEALTH HISTORY (Continued)

Other Doctors seen for this problem (please list) Chiropractor: _____ Medical Doctor _____
 Other: _____

Are you taking any of the following medications?

- Nerve Pills
 Pain Killers (including aspirin)
 Muscle relaxers
 Stimulates
 Blood thinners
 Tranquilizers
 Insulin
 Others: _____

Have you ever had any of the following diseases/medical condition(s)?

- | | | | |
|------------------------------------|-------------------------------|------------------------|--|
| Y N Heart Attack / Stroke | Y N Heart Surg. / Pacemaker | Y N Heart Murmur | Y N Pins and Needles in arms / Legs |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves | Y N Dizziness |
| Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N Numbness in Fingers |
| Y N HIV+ / AIDS | Y N Shingles | Y N Cancer | Y N Fatigue |
| Y N Frequent Neck Pain | Y N Emphysema / Glaucoma | Y N Anemia / Fainting | Y N Sleeping Problems |
| Y N Severe / Frequent Headaches | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Diarrhea |
| Y N High / Low Blood Pressure | Y N Kidney Problems | Y N Ulcers / Colitis | Y N Cold Sweats / Cold Hands / Cold Feet |
| Y N Fainting / Seizures / Epilepsy | Y N Sinus Problems | Y N Asthma | Y N Mood Swings |
| Y N Diabetes / Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy | Y N Loss of Smell |
| Y N Lower Back Pain | Y N Artificial Bones / Joints | Y N Arthritis | Y N Buzzing / Ringing in Ears |
| Y N Numbness in Toes | Y N Constipation | Y N Lights Bother eyes | Y N Menstrual Pain |
| Y N Loss of Taste | Y N Problem Urinating | Y N Menstrual Irreg. | Y N Loss of Balance |
| Y N Nervousness | Y N Heart Burn | Y N Hot Flashes | Y N Tension |

Please list anything that you may be allergic to: _____

List all previous Treatments with dates: _____

List any and all accidents with dates: _____

Are you wearing? Heel lifts Sole lifts Inner soles Arch supports What is the age of your mattress? _____ Is it comfortable? Y N

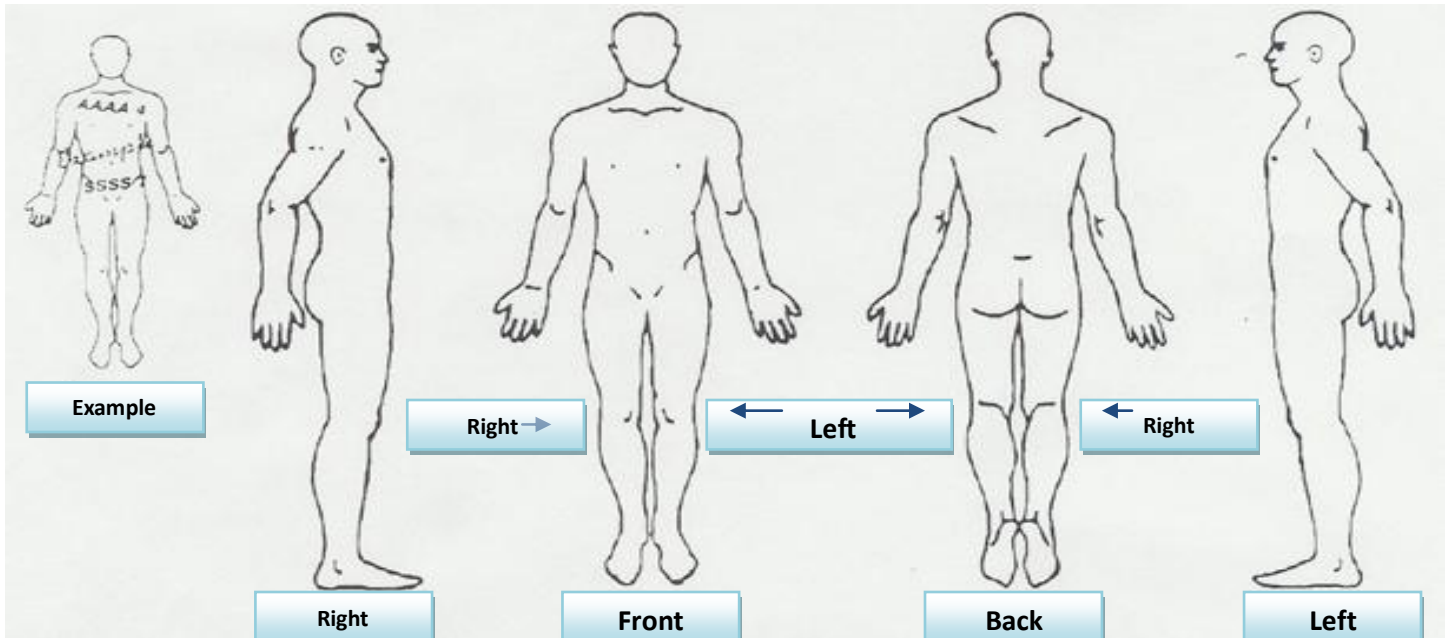
For Women: Are you taking Birth control? Y N Are you Pregnant? Y N If Yes how long? _____ Nursing? Y N

Please list any other problem(s) that you may have in the following areas: circulatory, digestive, infection, musculoskeletal, nervous system, reproductive, skin, or other health related problems that may not have been listed on this form. Some conditions may be a contraindication for Chiropractic and or massage. _____

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

- | | | | | |
|------------------------|----------------|---------|--------|----------|
| Description → Numbness | Pins & Needles | Burning | Aching | Stabbing |
| Symbol → NNNN | PPPP | BBBB | AAAA | SSSS |

Circle any area of pain not represented by a symbol.



Active Health Chiropractic

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Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided at 507 S. Fitness Pl. Suite 110, Eagle, Idaho 83616. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative

Date Signed

Relationship

Witness