Patient Information

Date: _____

Name: _____ Age _____
Address _____ City _____ State _____ Zip _____
Phone (Cell): _____ Carrier: _____ Email: _____
Social Security # _____ Date of Birth ___/____/____ Sex: [ ] Male [ ] Female
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
Employer: _____ Work Phone: _____
Occupation: _____
Spouse's Name: _____
Spouse's Employer: _____ Spouse Work Phone: _____
Spouse's Occupation: _____
In Case of Emergency: _____ Phone: _____

INSURANCE INFORMATION

Please present your insurance card to the front desk.

Who is responsible for this account? _____
Relationship to the patient: _____

If you are not the card holder, we must have:

Subscriber's Name: _____ Date of Birth: ___/___/_____
Insurance Carrier: _____ Member ID#: _____
Group #: _____ Phone # (on back of card): _____

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or the dependent) have insurance coverage and assign directly **to Action Chiropractic Inc.**, all insurance benefits, if any, Otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature Date

Relationship: [ ] Self [ ] Guardian of a Minor

ACCIDENT INFORMATION

Is your present condition due to an injury? [ ] Yes [ ] No
Type of Accident: [ ] Work Accident [ ] Auto Accident [ ] Other _____
Has the accident been reported? [ ] Yes [ ] No
If yes, to who? [ ] Employer [ ] Car Insurance [ ] Other _____
Attorney (if applicable): _____ Phone: _____

HEALTH CARE GOALS

Reason(s) for today's visit: _____

How did you hear about us? [ ] Internet search [ ] Our Website [ ] Doctor/Surgeon: _____
[ ] Social Media [ ] Google Reviews [ ] Attorney: _____
[ ] Insurance Network [ ] Drive By [ ] Friend/Family: _____
[ ] Other: _____

Are you interested in: [ ] Weight Loss [ ] Reformer Pilates [ ] Group Fitness Classes

Do you exercise? [ ] Never/Rarely [ ] Mildly [ ] Moderately [ ] Daily [ ] Heavily

If so, what type of exercise? [ ] Pilates [ ] Yoga [ ] Cycling [ ] Cross Fit
[ ] Weight Lifting [ ] Swimming [ ] Other: _____

Daily activities: [ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy Labor

Do you smoke? [ ] Yes [ ] No [ ] Former
If yes, for how many years? _____ If you quit, how many years ago? _____

HEALTH HISTORY:

Doctors seen for your condition: _____
List any diagnosis: _____
Have you had similar accidents or injuries before? [ ] Yes [ ] No
If yes, explain: _____
Have you received any of the following? [ ] Chiropractic [ ] Physical Therapy [ ] Medication
[ ] CT-Scan [ ] MRI [ ] Injections [ ] Surgery
Major Injuries/Falls: _____
Fractures: _____
Surgeries: _____

MEDICATION	DOSAGE	TIMES DAILY	VITAMINS/SUPPLEMENTS

ALLERGIES

_____ _____ _____ _____

Please check all that apply ["S" for Self and/or "F" for Family History]

CONSTITUTIONAL
___ Chills
___ Fever
___ Night Sweat
___ Weight Change
___ Muscle Aches
___ Weakness

EAR/NOSE/THROAT
___ Deafness
___ Hearing Loss
___ Ringing in Ear
___ Vertigo
___ Voice Changes

EYES
___ Blurred Vision
___ Visual Disturbance
___ Double Vision

CARDIOVASCULAR
___ Chest Pain
___ Hypertension
___ Hyperglycemia
___ Heart Palpitations
___ Irregular Rhythm
___ Shortness of Breath
___ Heart Attack

MUSCLES & JOINTS
___ Painful Joints
___ Stiff Joints
___ Weak Muscles
___ Loss of Movement
___ Muscle Atrophy
___ Scoliosis
___ Abnormal Posture

INTEGUMENTARY
___ Bruising Easily
___ Dryness
___ Itching
___ Allergy _____
___ Edema (ankles or Other)

NEUROLOGICAL
___ Incontinence
___ Night Sweat
___ Equilibrium Problems
___ Facial Weakness
___ Smell Disturbance
___ Visual Disturbance
___ Confusion
___ Dizziness
___ Headaches
___ Memory Loss
___ Seizure
___ Sensation Loss
___ Numbness
___ Tingling

PSYCHIATRIC
__ Anxiety
__ Depression
__ Mood Change
__ Bipolar

RESPIRATORY
__ Asthma
__ Emphysema
__ Chronic Cough
__ Difficulty Breathing
__ COPD

GENERAL
__ Cancer
__ HIV/AIDS
__ Hepatitis

Are you currently pregnant? [ ] Yes [ ] No

I hereby certify that the statements and answers given on these forms are accurate to the best of my knowledge and understand that it is my responsibility to inform this office to any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: ____/____/_____

List the areas of pain from most to least painful:

	1.	2.	3.
1. What side is the pain?	[ ] Left [ ] Right [ ] Both	[ ] Left [ ] Right [ ] Both	[ ] Left [ ] Right [ ] Both
2. Rate the pain (1-10 w/ 10 being worst)			
3. How did the pain start?	[ ] Gradual [ ] Sudden [ ] Accident/Fall	[ ] Gradual [ ] Sudden [ ] Accident/Fall	[ ] Gradual [ ] Sudden [ ] Accident/Fall
4. When did it start?	Date _____	Date _____	Date _____
5. Describe the pain?	[ ] Constant [ ] Intermittent	[ ] Constant [ ] Intermittent	[ ] Constant [ ] Intermittent
	[ ] Aching [ ] Dull [ ] Stiff [ ] Sharp [ ] Stinging [ ] Tingling	[ ] Aching [ ] Dull [ ] Stiff [ ] Sharp [ ] Stinging [ ] Tingling	[ ] Aching [ ] Dull [ ] Stiff [ ] Sharp [ ] Stinging [ ] Tingling
6. Radiation:	[ ] Arm [ ] Fingers [ ] Shoulder Blade [ ] Hip / Leg [ ] Foot / Toes	[ ] Arm [ ] Fingers [ ] Shoulder Blade [ ] Hip / Leg [ ] Foot / Toes	[ ] Arm [ ] Fingers [ ] Shoulder Blade [ ] Hip / Leg [ ] Foot / Toes
7. It Interferes with:	[ ] Daily Routine [ ] Normal Life Style [ ] Household Activities [ ] Sleep [ ] Work [ ] School	[ ] Daily Routine [ ] Normal Life Style [ ] Household Activities [ ] Sleep [ ] Work [ ] School	[ ] Daily Routine [ ] Normal Life Style [ ] Household Activities [ ] Sleep [ ] Work [ ] School
8. What makes it worse?	[ ] Sitting/Driving [ ] Standing Still [ ] Bending [ ] Movement/Exercise [ ] Resting	[ ] Sitting/Driving [ ] Standing Still [ ] Bending [ ] Movement/Exercise [ ] Resting	[ ] Sitting/Driving [ ] Standing Still [ ] Bending [ ] Movement/Exercise [ ] Resting
9. What makes it better?	[ ] Movement/Exercise [ ] Resting [ ] Cold/Hot Compress [ ] Medication	[ ] Movement/Exercise [ ] Resting [ ] Cold/Hot Compress [ ] Medication	[ ] Movement/Exercise [ ] Resting [ ] Cold/Hot Compress [ ] Medication

FINANCIAL AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT

FINANCIAL AGREEMENT

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any and all balance due to Action Chiropractic Inc.

Initial_____

AUTHORIZATION TO TAKE X-RAYS

I was advised that x-rays were a necessary component of a thorough spinal examination and a key component to aid in establishing the accurate diagnosis of my condition. I have also been informed that all x-rays will be destroyed after 7 years.

Initial_____

FEMALE ONLY

To the best of my knowledge, I am not pregnant and the doctor has my permission to take x-rays for diagnostic purposes.

Initial_____

FOR TREATMENT OF MINOR

I hereby authorize the doctor to perform any necessary examination and treatments, including x-rays as deemed necessary.

_____ (Relationship to minor)

_____ (Full name of minor)

_____ (Parent or Guardian signature) _____ (Date)

INFORMED CONSENT - AUTHORIZATION TO TREAT – HIPPA

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I am seeking treatment.

Patient (Or Guardian) Signature_____ Date _____

Acknowledgment of Receipt of Privacy Practices (HIPPA)

I, _____, have received a copy, read a copy or have been offered a copy of Action Chiropractic, Inc's Notice of Privacy Practices with an effective date of January 1, 2011.

Release of Information

I authorize the release of information including the diagnosis, records: examination rendered to me and claims information to:

( ) Spouse_____
( ) Children_____
( ) Other_____
( ) Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing

Name of Patient_____

Patient Signature Date

_____
(Parent, Legal Guardian, Caretaker

Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is severe and does not vary.

SECTION 2 – Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some Washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are positioned conveniently.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 – Walking

- ☐ I have no pain walking.
- ☐ I have some pain when walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ I avoid sitting because it increases pain immediately

SECTION 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- ☐ My social life is normal and gives me no pain
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 – Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain restricts all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.

GURUZ
FITNESS STUDIO

ACTION
CHIROPRACTIC
(501) 956 6080

Exercise Rehabilitation, Myofascial & Personal Training

Our Exercise Rehab Specialists and Personal Trainers are all self employed and coordinate their schedule with other facilities in order to make a living. To that effect, when we contract them specifically for the day and time that you request, they will turn down other opportunities to reserve your requested time. Our Myofascial Specialists (Nancy and Charlie) have a daily wait list of patients hoping to be fit into our schedule.

We understand that things may happen overnight or over the weekend that may prevent you from making your reserved time. Unfortunately, cancelations made after hours or over the weekend give too short of a notice to schedule someone else in your reserved time, prevents others from participating in this program, and causes irrecuperable loss of income for the instructors and for the establishment. We have some of the best instructors and myofascial specialists available and are proud to provide a rare and unique opportunity for all our patients and non-patients alike.

The rules set forward are not intended to penalize anyone for their misfortunes. The rules are necessary to preserve this unique program and ensure that our qualified instructors continue to help us make this program successful.

EFFECTIVE JUNE 1, 2021

_____ All appointments scheduled tomorrow cannot be cancelled in any way after today's regular office hours. *(ie: You cannot cancel Tuesday's appointment after 6pm Monday)*

_____ The same rule applies to Monday appointments, where the cancellation deadline is 3pm Friday to avoid a cancellation fee.

The office currently is closed on Monday and Wednesday at 6pm, Tuesday and Thursday at 5pm, and Friday at 3pm

_____ You will receive an appointment reminder the day before your appointment around 3pm. You can reply to the email, text, or call to modify or cancel your appointment before the office closes without a cancellation fee. (If you are not receiving our reminders, please ask the front front desk to test it)

_____ ANY CANCELLATION MADE AFTER HOURS, either through our portal, email, text, or voicemail WILL NOT BE ACCEPTED and will be subjected to the cancellation fee, REGARDLESS of the reason for your cancellation.

_____ ABSOLUTELY NO one is allowed to contact the instructor or the therapist directly to cancel or reschedule at any time.

_____ Reasons such as death in the family, flat tire, headaches, kids, work related issues, COVID scare or testing will all be addressed the same and are subject to the $25 missed appointment fee.

_____ All cancellation fees will be charged immediately upon missing your appointment to a credit card on file. If there is no credit card on file, we will collect a $25 cash deposit to keep on your account for that purpose.

We will credit back your account $25 if:

- We can fill your time slot at the last minute (Not a guarantee regardless of time)
- You provide us a valid excuse from your doctor
- You provide a COVID test result dated for the same day or the receipt of your doctor visit
- You provide a note from daycare or school, if your child's health was the reason for your late cancellation
- You provide us with evidence of death in the direct family.

Signature: _____ Date: _____

We reserve the right to decline services to anyone who repeatedly cancels or no-shows.