Active Health Solutions

Welcome to Our Office!

Name _____ Preferred Name_____
First MI Last

Physical Address _____
Address City/State/Zip

Mailing Address _____
Address City/State/Zip

Phone _____
Phone 1 Hm/Cell/Wk Phone 2 Hm/Cell/Wk Phone 3 Hm/Cell/Wk

Email Address _____

How would you like to receive appointment reminders? *Text*___ *Email*___ *Both*___ *None*___

Date of Birth _____ Gender _____ SSN _____ Occupation _____

Employment Status (Circle One): *Employed*___ *Student*___ *Retired*___ *Unemployed*___

Is your condition related to the following? Circle one if applicable. *Auto Accident*___ *Employment*___

Emergency Contact _____
Full Name Phone Number Relation to Patient

Referred By _____ Have you ever been treated by a chiropractor before? *Y*___ *N*___

If the patient is under the age of 18, please fill out the following:

Responsible Party Name _____Relation to patient _____
First MI Last

Physical Address _____
Address City/State/Zip

Mailing Address _____
Street City/State/Zip

Phone _____
Phone 1 Phone 2 Phone 3

Date of Birth _____ Gender _____ Social Security Number _____

Active Health Solutions
1000 O'Malley Road, Suite 102, Anchorage, Alaska 99515
Phone (907) 349-5552, Fax (907) 349-5100
activehealthsolutions@alaska.net

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PRIMARY INSURANCE INFORMATION

Insurance Company _____

ID Number (include prefix) _____Group Number _____

Name of Insured _____ DOB _____ Relation to Patient _____

Ins. Billing Address _____
Address City/State/Zip

SECONDARY INSURANCE INFORMATION

Insurance Company _____

ID Number (include prefix) _____Group Number _____

Name of Insured _____ DOB _____ Relation to Patient _____

Ins. Billing Address _____
Address City/State/Zip

TERTIARY INSURANCE INFORMATION

Insurance Company _____

ID Number (include prefix) _____Group Number _____

Name of Insured _____ DOB _____ Relation to Patient _____

Ins. Billing Address _____
Address City/State/Zip

Please make sure we get a copy of your insurance card(s) and photo ID.

We will bill your insurance company as a courtesy, but we have no formal contract with them. Any and all charges not paid by insurance within 30 days are your responsibility. In addition, if you do not show up for your scheduled appointment and do not call to cancel at least one day prior you will incur a $50 charge that cannot be billed to insurance.

Patient/Responsible Party Signature _____ **Date** _____

Mike Fleming, DC, C.C.S.P.
Ben Cain, DC, D.A.C.B.S.P., C.S.C.S.
Maya Radonich, DC, M.S.

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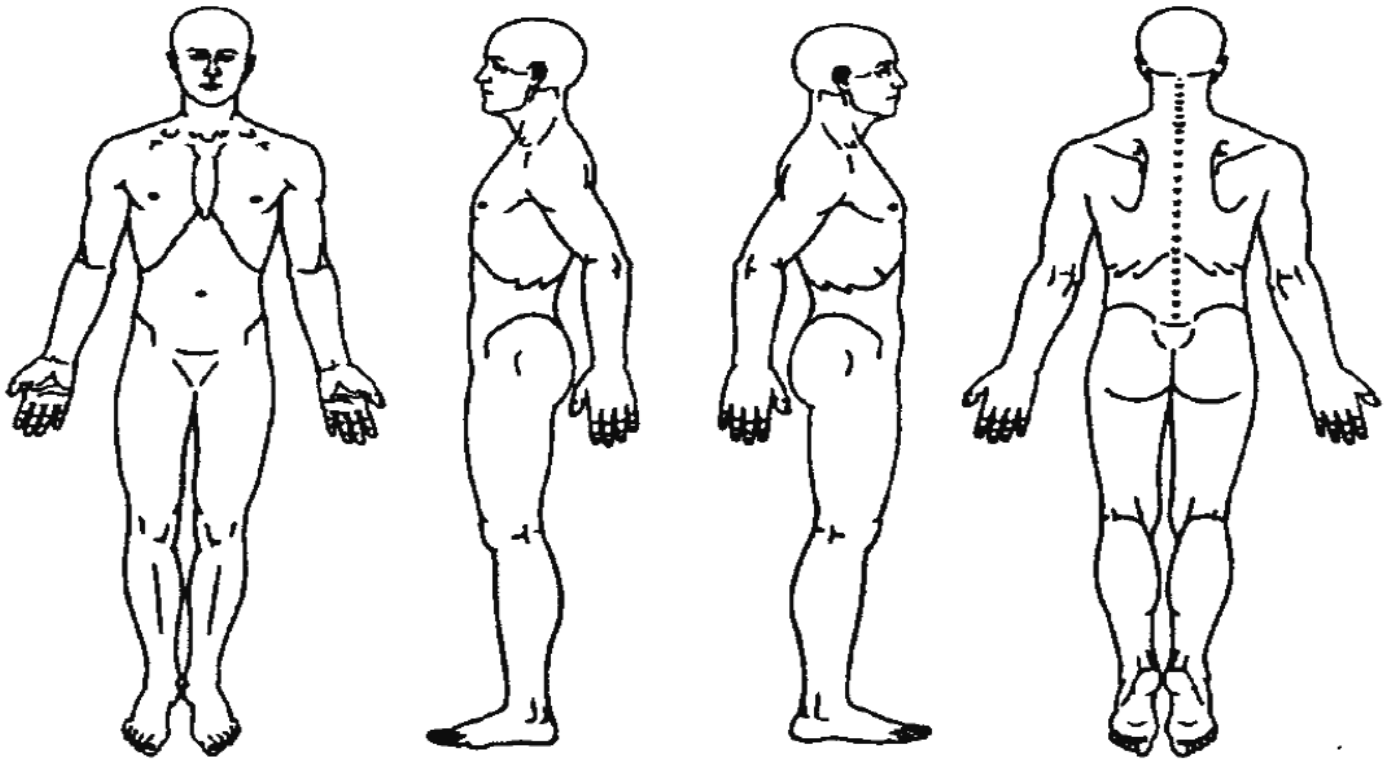
CONFIDENTIAL HEALTH HISTORY **PATIENT NAME: _____ DOB: _____**

Please Mark Area of Pain on the Drawing Using the Code Listed Below

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
===	Throbbing
000	Stabbing/Sharp



Chief Complaint: _____

Date of Onset: _____ Was the Onset ☐Gradual ☐Sudden Since onset, has it gotten: ☐Worse ☐Better ☐Same ☐Varies

Chief Complaint: Location (low back, knee, etc): _____

On a scale of 0-10, with 0 being no pain and 10 being the worst pain you've ever experienced, how would you rate the pain?:

Currently:	0	1	2	3	4	5	6	7	8	9	10
On Average:	0	1	2	3	4	5	6	7	8	9	10
When at its Worst:	0	1	2	3	4	5	6	7	8	9	10

Secondary Complaint (if present): Location (low back, knee, etc): _____

On a scale of 0-10, with 0 being no pain and 10 being the worst pain you've ever experienced, how would you rate the pain?:

Currently:	0	1	2	3	4	5	6	7	8	9	10
On Average:	0	1	2	3	4	5	6	7	8	9	10
When at its Worst:	0	1	2	3	4	5	6	7	8	9	10

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PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT**:

Describe the quality of the complaint/pain:

__ sharp
__ dull/ache
__ throbbing
__ tingling/numbness
__ stabbing
__ burning
__ shooting
__ weakness
__ other: _____

Does any of the following make pain worse?:

__ lifting/bending/pushing/pulling
__ cough/sneeze/bowel movement
__ driving/riding/sitting
__ walking/running/standing
__ other: _____

Describe if pain is in a single spot or does it radiate:

__ single location
__ radiating dull, deep ache
__ burning, sharp stabbing, tingling, numb
__ other: _____

Does any of the following make it better?:

__ rest/laying down
__ sitting
__ walking/exercise
__ other: _____

How often are you aware of the pain?:

__ intermittent (less than 25% of time when awake)
__ occasional (25-50% of time when awake)
__ frequent (50-75% of time when awake)
__ constant (75-100% of time when awake)

Does it interfere with your daily activities?:

__ minimal (annoyance, no impairment)
__ slight (tolerated, some impairment)
__ moderate (marked impairment)
__ marked (precludes any activity)

Have you experienced this current complaint previously at any time in the past?: ☐ Yes ☐ No If yes, when:_____

Was treatment provided? ☐ Yes ☐ No If yes, By whom: _____ Outcome: _____

Have you detected any possible relationship of your current complaint with any of the following?:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Dizziness ☐ Weight loss

☐ Loss of Fine Movement Control ☐ Problems with Speaking or Swallowing ☐ Vision Problems

Have you been treated or seen by another health care provider for your current complaint?: ☐ Yes ☐ No

If yes, by whom: _____ Specialty (MD, PT, DC, etc): _____ Outcome: _____

Have you tried any self-treatment or taken any medication (over-the-counter or prescription)?: ☐ Yes ☐ No

If yes, explain: _____

Have you had any imaging for your current complaint (X-ray, MRI, CT, etc)?: ☐ Yes ☐ No

If yes, please state type, result, date and place: _____

Does your complaint affect your ability to sleep?: ☐ Yes ☐ No

Please note anything else you would like the doctor to know about your chief complaint: _____

_____

_____

TREATMENT GOALS:

On a scale of 0-10 with 0 being no pain, what is a reasonable level of pain you hope to achieve with treatment?: _____

What activity can you not perform currently that you would like to be able to do once treatment is finished? (Examples: play round of golf w/ no low back pain, run 3 miles w/out knee pain, sit down without pain): _____

_____

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PAST HEALTH HISTORY:

In general, would you say your health is (check one): ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgery	Treatment	Outcome

Are you presently taking any prescription drugs, over-the-counter drugs, vitamins or supplements? ☐ Yes ☐ No

Product/Drug	Reason	Dosage	Frequency

FAMILY HISTORY AND HEALTH STATUS: List any family diseases, disorders, or major illnesses:

_____

_____

_____

SOCIAL HISTORY: Please choose Yes or No for the following questions:

☐ Yes ☐ No Do you exercise? How many times per week? _____ Type(s): _____

☐ Yes ☐ No Do you smoke? If yes, how much per day? _____ If you have quit, when did you quit? _____

☐ Yes ☐ No Do you use other forms of tobacco? If yes, what & how much per day? _____

☐ Yes ☐ No Do you consume alcohol? If yes, how many drinks per week? _____

☐ Yes ☐ No Do you eat a balanced diet? If no, explain: _____

☐ Yes ☐ No Do you get adequate sleep? If no, explain: _____

☐ Yes ☐ No Is work stressful to you? If yes, explain: _____

☐ Yes ☐ No Is family/social life stressful? If yes, explain: _____

☐ Yes ☐ No Do you use recreational drugs? If yes, explain: _____

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SYSTEMS REVIEW QUESTIONS:
List any past or present symptoms or conditions regarding the following systems:

GENERAL (dizziness, nausea, fatigue, depression, anxiety, etc): _____
_____
_____

MUSCULOSKELETAL (arthritis, pain, etc): _____
_____
_____

CARDIOVASCULAR (high BP, pain over heart, ankle swelling, etc): _____
_____
_____

EYES, EARS, NOSE, THROAT (colds, sore throat, deafness, thyroid issues, allergies, etc): _____
_____
_____

RESPIRATORY (chest pain, chronic cough, wheezing, asthma, etc): _____
_____
_____

GASTROINTESTINAL (colon issues, nausea, vomiting, gallbladder problems, digestion issues, etc): _____
_____
_____

GENITO-URINARY (frequent urination, inability to control bladder, irregular menstrual cycle, kidney issues, etc): _____
_____
_____

Females: Date of last gynecological and breast exam: _____ Date of last menstrual cycle: _____
Males: Date of last prostate exam: _____

Please read and sign: I hereby state that all information that I have provided is complete and truthful to the best of my knowledge .

SIGNATURE: _____ DATE: _____

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Informed Consent for Chiropractic Treatment

Doctors of chiropractic, medical doctors, and physical therapists who use manual therapy are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;

b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spine adjustment is extremely remote;

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or spinal treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Printed Full Name of Patient _____

Signature of Patient or Guardian _____ Date_____

Signature of Witness _____ Date _____

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ACTIVE HEALTH SOLUTIONS

Michel Fleming, LLC
Dr. Ben Cain, LLC
Radonich Chiropractic LLC
1000 O'Malley Rd, Ste 102, Anchorage, AK 99515

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to make available to you a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy of our current Notice of Privacy Practices is available in our office and on our website. You are entitled to a copy of our Notice of Privacy Practices. Please sign this form to acknowledge the Notice of Privacy Practices was made available to you.

I am aware that a new Notice of Privacy Practices is in effect as of April 25, 2018. I acknowledge that this copy of Active Health Solutions' Notice of Privacy Practices was made available to me.

_____
Patient's Printed Name

_____
Signature of Patient, Parent, or Legal Guardian

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgment.

_____ _____
Employee Signature Date