

 **INTAKE FORM**

PATIENT NAME	
DATE OF BIRTH	
ADDRESS	
CITY STATE ZIP	
PHONE NUMBER	
EMAIL ADDRESS	



Is your visit with us today related to an auto accident or work-related injury?

NO YES: AUTO - OR - WORK

PRIMARY COMPLAINT

PLEASE COMPLETE THE NEXT SECTION FOR YOUR PRIMARY REASON FOR YOUR VISIT.

Please only describe one body region. You will be able to add additional complaints later.

Which body region are you experiencing your symptoms (pain, discomfort, lack of function, etc.)?

Rate your symptom intensity using the scale below by circling a number below:

0 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS MILD WINCING MODERATE HOSPITALIZED

Describe your symptoms:

SHARP DULL ACHY THROBBING BURNING TINGLING NUMB

Do your symptoms for this body region radiate to another body part?

NO YES, DESCRIBE THE FURTHEST POINT YOUR SYMPTOMS RADIATE TO: _____

More recently, when did you notice this episode of your symptoms start?

The onset of symptoms started GRADUALLY SUDDENLY

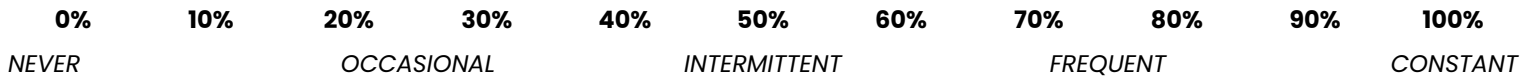
What do you think happened that may have caused these symptoms?

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Circle any of the activities that aggravate or worsen your symptoms for this complaint:

sitting (slouched)	sitting (up tall)	texting / using a cell phone
bending over	concentrating	household chores
standing	reaching overhead	climbing stairs
chewing	grocery shopping	walking
talking	lying down	getting to sleep
love life	getting dressed	staying asleep
looking over the shoulder using a computer	driving a car	caring for family
yard work	rising out of a chair sitting down to a chair	getting in / out of a car occupation
	exercising	showering / bathing
	lifting objects	

How frequently do these symptoms interfere with your normal activities (usual daily routines)?



Are there any activities that relieve or lessen your symptoms?

What time of day do you notice symptoms appear most?

- NEVER
 MORNING
 AFTERNOON
 EVENING
 NIGHT
 CONSTANT

Describe any previous / current treatment you've had for this symptom (ice, medication, therapy, etc.)

SECONDARY COMPLAINT

PLEASE COMPLETE THE NEXT SECTION FOR YOUR PRIMARY REASON FOR YOUR VISIT.

Please only describe one body region. You will be able to add additional complaints later.

Which body region are you experiencing your symptoms (pain, discomfort, lack of function, etc.)?

Rate your symptom intensity using the scale below by circling a number below:



Describe your symptoms:

- SHARP
 DULL
 ACHY
 THROBBING
 BURNING
 TINGLING
 NUMB

Do your symptoms for this body region radiate to another body part?

- NO
 YES, DESCRIBE THE FURTHEST POINT YOUR SYMPTOMS RADIATE TO: _____

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More recently, when did you notice this episode of your symptoms start?

The onset of symptoms started GRADUALLY SUDDENLY

What do you think happened that may have caused these symptoms?

Circle any of the activities that aggravate or worsen your symptoms for this complaint:

sitting (slouched)

bending over

standing

chewing

talking

love life

looking over the shoulder using

a computer

yard work

sitting (up tall)

concentrating

reaching overhead

grocery shopping

lying down

getting dressed

driving a car

rising out of a chair sitting down

to a chair

exercising

lifting objects

texting / using a cell

phone household chores

climbing stairs

walking

getting to sleep

staying asleep

caring for family

getting in / out of a car

occupation

shower

ing / bathing

How frequently do these symptoms interfere with your normal activities (usual daily routines)?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
NEVER OCCASIONAL INTERMITTENT FREQUENT CONSTANT

Are there any activities that relieve or lessen your symptoms?

What time of day do you notice symptoms appear most?


NEVER MORNING AFTERNOON EVENING NIGHT CONSTANT

Describe any previous / current treatment you've had for this symptom (ice, medication, therapy, etc.)

ADDITIONAL COMPLAINTS



Do you have any additional complaints you would like us to evaluate?

NO YES: Please describe below 



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HEALTH HISTORY

SURGERIES / ILLNESS / ACCIDENTS - List with an estimate of your age or the date performed.

SURGERY / ILLNESS / ACCIDENT	DATE OR AGE
•	
•	
•	

MEDICATIONS - List below any prescribed or over the counter medications you are taking.

MEDICATION	PURPOSE
•	
•	
•	

REVIEW OF SYSTEMS

Musculoskeletal

No Issue Known Issue, describe:

Respiratory

No Issue Known Issue, describe:

Blood

No Issue Known Issue, describe:

Neurological

No Issue Known Issue, describe:

Gastrointestinal

No Issue Known Issue, describe:

Skin

No Issue Known Issue, describe:

ENT: Ear, Nose Throat

No Issue Known Issue, describe:

Genitourinary

No Issue Known Issue, describe:

Cardiovascular

No Issue Known Issue, describe:

Endocrine

No Issue Known Issue, describe:

 **INTAKE FORM****SOCIAL HISTORY**

Please indicate the appropriate selection by marking an 'X' in the matching column.

	Daily	Few Times per Week	Weekly	Few Times per Month	Monthly	Rarely	Never
Alcohol Use							
Caffeine Use							
Tobacco Use							
Exercise							
Pain Reliever Use							
Water Consumption							
Job Pressure/Stress							
Family / Life Stress							

ADDITIONAL DETAILS

Is there anything else we should know?

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

- Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.
- Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
- Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.
- Stroke: There are reported cases of stroke associated with common neck movements including rotation manipulation of the upper cervical spine. This technique is NOT used. Present medical and scientific evidence does not establish a definite cause and effect relationship between the cervical spine manipulation and the occurrence of stroke. There are reported rates of occurrence showing 1 in 1 million to 1 in 10 million will experience stroke. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. You are being informed of the possibility regardless of the extreme remote chance.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree with the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

- Other treatments including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery may be reasonable alternative procedures or treatment of my condition including medications. Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
- Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
- Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.
- Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

<p>I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.</p> <p>X_____ PATIENT / GUARDIAN SIGNATURE</p>	<p>STAFF INITIALS</p>
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INTAKE FORM

FINANCIAL POLICY

Insurance Verification | Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. As a courtesy we provide an estimate based on the current fee schedule for your insurance carrier. This estimate may be slightly lower or higher than your actual incurred charges due to misinformation, case complications or additional or less therapies needed. Insurance companies review charges individually and make payment accordingly. Charges not covered by insurance are the patient's responsibility and due within 30 days of billing. We recommend each patient verify chiropractic benefits by referring to the plan summary provided by the insurance company or by calling the customer service phone number located at the bottom or back of your insurance card.

Deductible Payments | It is our policy to collect at time of service. Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance | Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service. If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. Payment is due within 30 days of receipt of the bill. In the event a bill is disputed, you must notify us within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue interest at the rate of 18% per annum. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees, court costs or collection fees incurred by us. All balances remaining unpaid after 30 days may be reported to a credit bureau and affect your credit rating.

Returned Checks | It is our policy to collect \$25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments | If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a \$20 charge added towards your account each visit that is missed. The patient will be responsible for payment. For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your case manager and primary physician. This may jeopardize your claim.

Financial Policy Questions | We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Cassie Hulme by contacting the office at 615-537-5520 or by e-mail at Cassie@activesports.care.

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

Active Sports Therapy is authorized to release any information you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I authorize my attorney and/or insurance company to make direct payment to you of settlement proceeds. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due I personally owe to you. I further agree that this Authorization of Assignment is irrevocable until all monies owed to Active Sports Therapy are paid in full.

I have read and agree to the financial policy, assignment and authorization.

X_____ PATIENT / GUARDIAN SIGNATURE

STAFF
INITIALS



INTAKE FORM

NOTICE OF INFORMATION PRIVACY PRACTICES

How We Collect Information About You | Active Sports Therapy (AST) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that are either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information | Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information | Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between AST and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance, etc.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect | We do not use cookies on our website to collect data from our site visitors. We do use some affiliate programs that may or may not capture trac data through our site.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, Videos and Other Sources | Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of AST. Additionally, videos recorded in the office may be used for educational or case research purposes. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising, promotional or educational purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without the client's express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information that you send to us will ever be publicly used without your direct or indirect consent.

I have been notified of privacy practices.

X_____ PATIENT / GUARDIAN SIGNATURE

STAFF
INITIALS