



# Active Spine Chiropractic

570 Williamson Road • Mooresville, NC 28117  
704-663-7625 • ActiveSpineNC.com

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To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

## Assignment of Benefits

IN CONSIDERATION of the willingness of **Active Spine Chiropractic** to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to **Active Spine Chiropractic** any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on the following date: \_\_\_\_\_ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to **Active Spine Chiropractic**, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such as sums as are due or may become due to **Active Spine Chiropractic** for its services rendered.

I appoint **Active Spine Chiropractic** as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with **Active Spine Chiropractic**.

I authorize **Active Spine Chiropractic** to release any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to **Active Spine Chiropractic** for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If **Active Spine Chiropractic** is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse **Active Spine Chiropractic** for its costs of recovery, including reasonable attorney's fees.

\_\_\_\_\_  
*Patient Name (PLEASE PRINT)*

\_\_\_\_\_  
*Claim Number*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

## Notice of Lien

Pursuant to N.C.G.S. 44-49 and 44-50, **Active Spine Chiropractic** hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

**Active Spine Chiropractic** hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. **Active Spine Chiropractic** agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

*Active Spine Chiropractic*

By: \_\_\_\_\_



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## Welcome

The doctors and staff of Active Spine Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

## Insurance

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

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## Patient Identification

-PLEASE PRINT-

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name (Legal)

\_\_\_\_\_  
Preferred to be Called

\_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
Birthdate

\_\_\_\_-\_\_\_\_-\_\_\_\_  Married  Single  Widowed  
Social Security Number

\_\_\_\_\_  
 Employer  School  Full-Time  Part-Time  Not Employed  
 Self-Employed  Retired  Active Military

\_\_\_\_/\_\_\_\_-\_\_\_\_  
Home Phone

\_\_\_\_/\_\_\_\_-\_\_\_\_  
Work Phone

\_\_\_\_/\_\_\_\_-\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Emergency Contact

\_\_\_\_/\_\_\_\_-\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

(We only use your email for contact, newsletters and updates about our practice. We do not share emails with or sell to any third-party.)

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## Acceptance As Patient

I understand and agree that the doctors of Active Spine Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## Details of Accident

Type of Accident  Automobile  Workers Compensation  Slip and Fall

In your own words, the please describe the Accident

\_\_\_\_\_

Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of the Accident \_\_\_\_:\_\_\_\_  am  PM

Address or Location of Accident \_\_\_\_\_

The Patient's Position was:  Driver  Front Passenger  Left Rear Passenger  
 Right Rear Passenger  Middle Front Passenger  Middle Rear Passenger

Patient's Vehicle Speed: \_\_\_\_\_ mph Other Vehicle Speed: \_\_\_\_\_ mph

*Damage to Patient's Vehicle:*  
 Mild  Moderate  Extensive  Totaled

*Visibility*  
 Poor  Fair  Good

*The Weather was*  
 Snowing  Raining  Windy  Foggy  Clear

*Who Hit Who/What?*  
 Patient Hit Other Vehicle  
 Patient Hit Other Object  
 Other Vehicle Hit Patient

*Point of Impact*  
 Front  Left Front  Right Front  Rear  
 Left Rear  Right Rear  Left Side  Right Side

*Was the Patient Using the Seatbelt?*  Yes  No

*Was the Patient Using the Shoulder Harness?*  Yes  No

*Does the Vehicle Have an Airbag?*  Yes  No

*Was the Airbag Deployed?*  Yes  No

*Did the Patient Strike Anything on the Vehicle?*  Yes  No  
*If Yes, What?*  
 Wheel  Armrest  Windshield  Airbag  
 Dashboard  Side Door  Side Window

*Where? (Part of the Body)*  
\_\_\_\_\_  
\_\_\_\_\_

*Did the Patient See the Accident Coming?*  Yes  No

*Does the Vehicle Have Headrest?*  Yes  No  
*What Position?*  
 Even with Top of Head  
 Middle of Neck  
 Even with Bottom of Head

*Was The Patient Braced For The Impact?*  Yes  No

*Was The Patient Dazed?*  Yes  No

*Did the Patient Lose Consciousness?*  Yes  No

*If Yes, for How Long?* \_\_\_\_\_

*Direction of Head*  
 Facing Straight Forward  
 Turned to the Left  
 Turned to the Right

*Was The Head Injured?*  Yes  No

*Other Part Injured* \_\_\_\_\_

*Did the Patient Experience any of the following:*  
 Bruises Where? \_\_\_\_\_  Bleeding Where? \_\_\_\_\_  
 Abrasions Where? \_\_\_\_\_  Fracture Where? \_\_\_\_\_  
 Lacerations Where? \_\_\_\_\_  Burns Where? \_\_\_\_\_  
 Swelling Where? \_\_\_\_\_

*Immediately After the Accident, Patient Experienced:*  
 Headaches  Neck Pain  Low Back Pain

*Other:* \_\_\_\_\_



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## Hospital Information

Did The Patient Go To The Hospital?  Yes  No

What Hospital: \_\_\_\_\_

Transportation to Hospital by  Ambulance  Drove Self  Somebody Else  Police

Tests Done at the Hospital  X-Rays  MRI  CT-Scan  Lab Work

Other Tests \_\_\_\_\_

Any Prior Doctor for this Accident?  Yes  No *If Yes, Please List Other Doctors and Tests*

Dr.'s Name \_\_\_\_\_

Dr.'s Name \_\_\_\_\_

Tests Performed \_\_\_\_\_

Tests Performed \_\_\_\_\_

## Since the Accident

Since the Accident, the Patient is  Better  Same  Worse

Has the Patient Lost Time from Work?  Yes  No *If yes, How Long?* \_\_\_\_\_

Can The Patient Physical Work Activities?  Yes  No *If No, Why?*  Pain  Weakness  Stress  Other

Can the Patient go to Sleep Without Problems?  Yes  No

Does the Patient Awaken Because of Pain?  Yes  No

Did the Patient Ever Have Sleeping Problems?  Yes  No *If yes, Where?* \_\_\_\_\_

Patient's Occupation \_\_\_\_\_

Duty of Job Detail is:  Light  Regular  Heavy

Is there Financial Burden for the Patient and Family?  Yes  No

*If Yes, Please Explain* \_\_\_\_\_

### Since the Accident, the Patient is Having Problems with:

- |                                   |                                   |                                     |                                       |                                     |  |
|-----------------------------------|-----------------------------------|-------------------------------------|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Seeing   | <input type="checkbox"/> Tasting  | <input type="checkbox"/> Smelling   | <input type="checkbox"/> Eating       | <input type="checkbox"/> Nervous    | <input type="checkbox"/> Tactile Feeling       |
| <input type="checkbox"/> Hearing  | <input type="checkbox"/> Bathing  | <input type="checkbox"/> Grooming   | <input type="checkbox"/> Dressing     | <input type="checkbox"/> Irritable  | <input type="checkbox"/> Loss of Concentration |
| <input type="checkbox"/> Reading  | <input type="checkbox"/> Typing   | <input type="checkbox"/> Writing    | <input type="checkbox"/> Grasping     | <input type="checkbox"/> Sports     | <input type="checkbox"/> Change in Personality |
| <input type="checkbox"/> Holding  | <input type="checkbox"/> Pinching | <input type="checkbox"/> Standing   | <input type="checkbox"/> Leaning      | <input type="checkbox"/> Reclining  | <input type="checkbox"/> Restful Sleeping      |
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Stooping | <input type="checkbox"/> Squatting  | <input type="checkbox"/> Climbing     | <input type="checkbox"/> Insomnia   | <input type="checkbox"/> Loss of Sexual Drive  |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Bending  | <input type="checkbox"/> Twisting   | <input type="checkbox"/> Carrying     | <input type="checkbox"/> Exercising | <input type="checkbox"/> Using the Toilet      |
| <input type="checkbox"/> Lifting  | <input type="checkbox"/> Pushing  | <input type="checkbox"/> Pulling    | <input type="checkbox"/> Reaching     |                                     |  |
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Driving  | <input type="checkbox"/> Riding Car | <input type="checkbox"/> Plane Travel |                                     |  |

## Other Accidents

Has the Patient Been in an Accident Before?  Yes  No *If Yes, What Year?* \_\_\_\_\_

List Details (ie X-Rays, Tests, Lab Work, etc.) \_\_\_\_\_

Any Residual Problems?  Yes  No : *If Yes, Please Explain* \_\_\_\_\_



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Patient Name \_\_\_\_\_

Date \_\_\_\_\_

- |  |                                     |                                    |
|--|-------------------------------------|------------------------------------|
| Do you have vertigo (dizziness)?   | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you pass out easily (faint or loss of consciousness)?</b>                      | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have double vision or have you lost sight in one eye?                         | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have any slurred speech or difficulty with speech?</b>                     | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have indigestion or difficulty swallowing?                                    | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have any difficulty walking, with coordination or falling to one side?</b> | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have nausea or vomiting?  | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have numbness on one side of your face or body?</b>                        | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have any visual disturbances or rapid eye movement?                           | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have or have you ever had difficulty in arranging words properly?</b>      | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have a headache or head pain that is unlike any you have had before?          | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have headaches for hours or days?</b>                                      | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have chest pain?  | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have difficulty breathing?</b>   | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have any change in bowel or bladder habits?                                   | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have a sore that does not heal?</b>  | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have any unusual bleeding or discharge?                                       | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have any thickening in your breasts or elsewhere?</b>                      | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have a change in any wart or mole?  | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have a nagging cough or hoarseness?</b>                                    | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have night sweats?  | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have pain in neck, jaw or face?</b>  | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Do you have a drooping eyelid or change in your pupils?                              | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Do you have any ringing in your ears?</b>   | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Does your pain ever wake you from a sound sleep?                                     | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Are you losing or gaining weight now without trying?</b>                          | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Are you coughing up blood or noticing it in your stools or urine?                    | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Have you had any loss of bladder or bowel control?</b>                            | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Have you lost consciousness or had double vision recently?                           | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Are you seeing any other doctor now for any reason?</b>                           | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Have you felt fatigued or weak for no apparent reason?                               | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |
| <b>Has there recently been a change in your appetite?</b>                            | <input type="checkbox"/> <b>Yes</b> | <input type="checkbox"/> <b>No</b> |
| Have you had a recent fever or chills?   | <input type="checkbox"/> Yes        | <input type="checkbox"/> No        |

Additional Comments: \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



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Complaint : \_\_\_\_\_

Pain Came On:  Gradually  Immediately  
Pain Is Getting:  Better  Same  Worse

Grade: \_\_\_\_\_ (On A Scale Of 1-10, 1=good 10=bad)

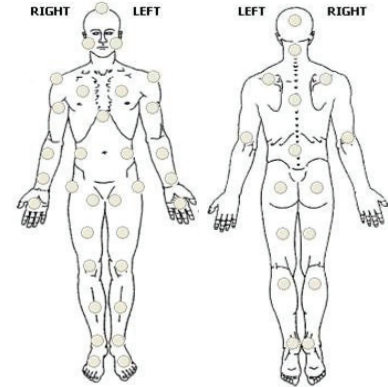
Intensity:  Minimal  Slight  Moderate  Severe  
Frequency:  Intermittent  Occasional  Frequent  Constant

Describe Feeling:  Dull  Sharp  Aching  Shooting  
 Spasm  Throbbing  Burning  Numbing  
 Tingling  Other: \_\_\_\_\_

How Long Has It Been Hurting: \_\_\_\_\_

How Did You Get This Injury: \_\_\_\_\_

Circle the area where you have PAIN:



Please check mark the Actions Affecting this Pain: (B) Brings On (A) Aggravates (R) Relieves

In the Morning: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	In the Afternoon: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Forward: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Bending Back: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Twisting Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Twisting Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Coughing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Sneezing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Straining: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Standing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Lifting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Sitting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Heat: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Cold: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Rest: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Lying Down: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Medications: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R		

Nothing Relieves the Pain Other : \_\_\_\_\_  B  A  R

### Pain Radiates To:

Head: <input type="checkbox"/> Right <input type="checkbox"/> Left	Neck: <input type="checkbox"/> Right <input type="checkbox"/> Left	Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left
Arm: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left
Leg: <input type="checkbox"/> Right <input type="checkbox"/> Left	Foot: <input type="checkbox"/> Right <input type="checkbox"/> Left	

Pain Also Radiates To: \_\_\_\_\_

Complaint : \_\_\_\_\_

Pain Came On:  Gradually  Immediately  
Pain Is Getting:  Better  Same  Worse

Grade: \_\_\_\_\_ (On A Scale Of 1-10, 1=good 10=bad)

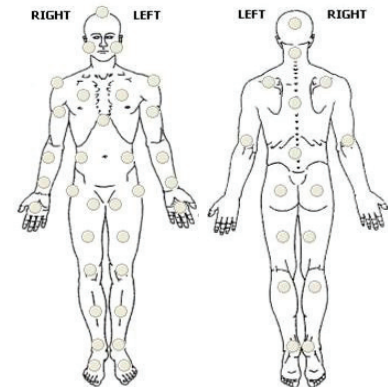
Intensity:  Minimal  Slight  Moderate  Severe  
Frequency:  Intermittent  Occasional  Frequent  Constant

Describe Feeling:  Dull  Sharp  Aching  Shooting  
 Spasm  Throbbing  Burning  Numbing  
 Tingling  Other: \_\_\_\_\_

How Long Has It Been Hurting: \_\_\_\_\_

How Did You Get This Injury: \_\_\_\_\_

Circle the area where you have PAIN:



Please check mark the Actions Affecting this Pain: (B) Brings On (A) Aggravates (R) Relieves

In the Morning: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	In the Afternoon: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Forward: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Bending Back: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Bending Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Twisting Left: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Twisting Right: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Coughing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Sneezing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Straining: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Standing: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Lifting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Sitting: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Heat: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Cold: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Rest: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R	Lying Down: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R
Medications: <input type="checkbox"/> B <input type="checkbox"/> A <input type="checkbox"/> R		

Nothing Relieves the Pain Other : \_\_\_\_\_  B  A  R

### Pain Radiates To:

Head: <input type="checkbox"/> Right <input type="checkbox"/> Left	Neck: <input type="checkbox"/> Right <input type="checkbox"/> Left	Shoulder: <input type="checkbox"/> Right <input type="checkbox"/> Left
Arm: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	Hip: <input type="checkbox"/> Right <input type="checkbox"/> Left
Leg: <input type="checkbox"/> Right <input type="checkbox"/> Left	Foot: <input type="checkbox"/> Right <input type="checkbox"/> Left	

Pain Also Radiates To: \_\_\_\_\_



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*Please list your Past Medical Conditions (i.e. Heart Disease, High Cholesterol, Cancer, etc.)*

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*Please list Medical Conditions of Family Members (i.e. Heart Disease, High Cholesterol, Cancer, etc. : (Heart Disease - Mother's Father))*

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*Please list any Past Surgical Procedures with dates (i.e. Knee Surgery, Heart Surgery, etc.)*

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*Please list the Medications, Vitamins, and Nutritional Supplements that you are currently taking.*

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*Please list any Allergies you may have (i.e. Sulfur, Penicillin, Pets, Seafood, etc.)*

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Please check one:  Married  Single  Divorced  Widowed  Separated

Do you use any of the following:  Tobacco  Alcohol  Coffee How many Children do you have? \_\_\_\_\_

**BY THE END OF TREATMENT, THE PATIENT WOULD LIKE TO BE ABLE TO:**

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*Patient Signature*

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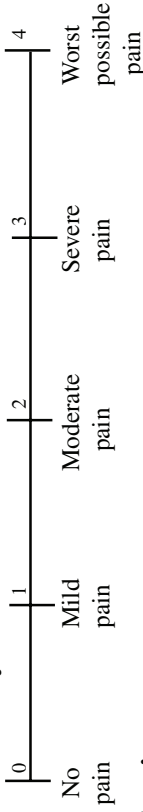
*Date*

# Functional Rating Index

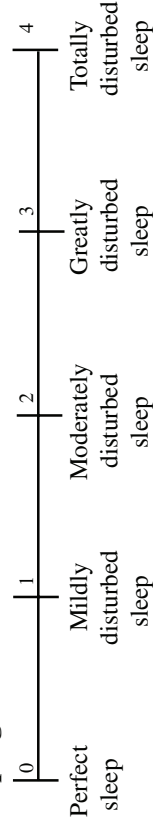
- FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY -

In order to properly assess your condition, we must understand how much *your neck and/or back problems* have affected your ability to manage everyday activities. For each item below, *please circle the number which most closely describes your condition right now.*

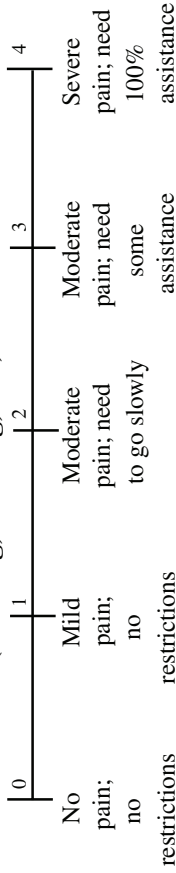
## 1. Pain Intensity



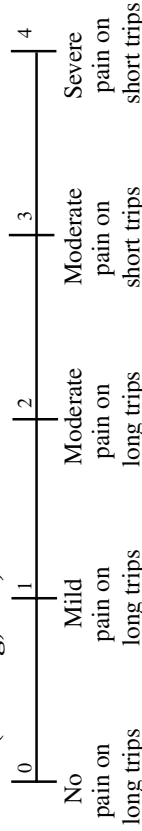
## 2. Sleeping



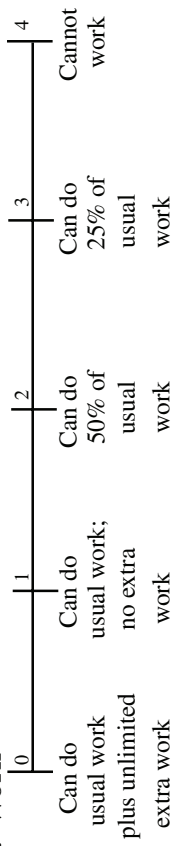
## 3. Personal Care (washing, dressing, etc.)



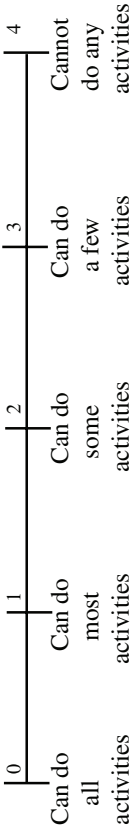
## 4. Travel (driving, etc.)



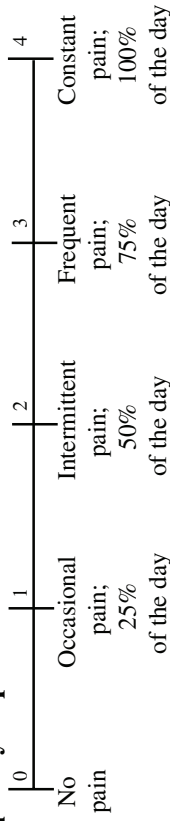
## 5. Work



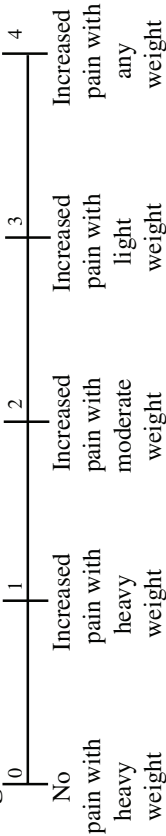
## 6. Recreation



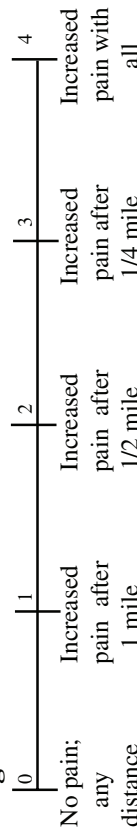
## 7. Frequency of pain



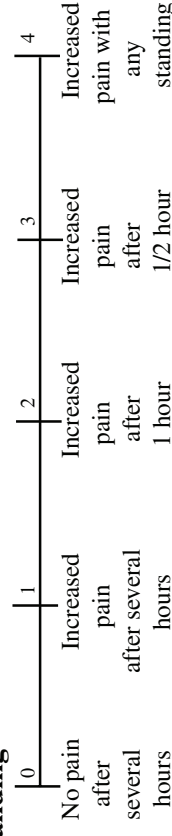
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

**PRINTED**

Signature \_\_\_\_\_

**Total Score** \_\_\_\_\_

Date \_\_\_\_\_





# Active Spine Chiropractic

570 Williamson Road • Mooresville, NC 28117  
704-663-7625 • ActiveSpineNC.com

## Assignment of Insurance Benefits

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Insured's Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Insured's Date of Birth

\_\_\_\_\_  
Insured's Address (if different from Patient)

I authorize and direct that payment be made directly to:

**Active Spine Chiropractic, 570 Williamson Road, Mooresville, NC 28117**

For any and all insurance benefits or reimbursement for services rendered by Active Spine Chiropractic which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

## Release of Information

By signing below, I authorize the release of any information concerning my health and health care services to my insurance companies, other health care professionals, or hospitals when necessary for diagnosis, assessment, or treatment of my health condition. I also authorize the release of any health information and billing records to another party if they are potentially responsible for payment of my services.

## Payment Agreement

I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I also understand that if my account becomes delinquent, Active Spine Chiropractic will utilize the services of a collection agency. If this action is needed, I will be responsible for any additional fees accumulated to collect my outstanding balance.

## Consent To Care

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 seek treatment.

## HIPPA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review this Chiropractic Offices's Notice of HIPPA Privacy Practices for protected health information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date