ACTIVE LIFESTYLES
WELLNESS & PERFORMANCE CTR.
chiropractic, physical therapy & nutritional counseling

We thank you for choosing our facility for your wellness needs. It is very important to us to deliver the best possible care to you and to all our clients. In trying to do so, we ask that you follow the plan of care given to you which includes your home exercise program and your scheduled appointments.

We strongly value timeliness in our office and we try to minimize waiting periods. We realize that your time is just as valuable as ours. Therefore we would like for you to respect our **24 hour cancellation policy** so we can schedule appointments most efficiently.

We value your business and the business you provide us with your referrals. If you are satisfied with our services, we encourage you to refer a friend or a loved one or write us your testimonial. Also, if you have any suggestions on how to improve our services please let us know.

Our mission is to provide the best care possible through chiropractic, physical therapy, massage and supplement (vitamin)/nutritional therapy. Dr. Res and his staff attend many seminars to assure that you get the best care possible. Ask about the latest ventures and he will be happy to share them with you.

We strongly recommend you fill out all the forms attached and return them fully completed prior to your appointment. Also, we recommend you provide all imaging (X-Ray, MRI CT scan) reports in your possession relevant to your current complaint.

The Doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease. ---Thomas A. Edison

Best wishes of Health,

Your Healthcare Team at Active Lifestyles.

1715 37th Place, Third Floor, Vero Beach, FL, 32960.
www.activevero.com*, *info@activevero.com
Tel No. 772-978-7379, Fax: 772-539-8515

OFFICE USE Only: BP____/_____ Weight_____lbs Pulse___bpm Height: _____ Temp:_____
PrimaryInsurance:_____Secondary:_____ Co-Pay:_____

To save time and allow us to better serve you, please complete ALL questions on the next pages. Thank you!

Personal History_____**Elbow and Hand Forms Only**

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone:_____ Birthdate: _____Age: _____ Sex: M ☐F ☐
E-Mail:_____ _Social Security # _____

Business/Employer (Past work if retired): _____ Business Phone: _____
Address: _____
City: _____ State:____Zip Code: _____
Type of Work currently or performed in the past: _____

Circle One: Married Single Widowed Divorced Separated Other Number of Children:_____
Spouse's Name: _____
Emergency Contact: _____ Phone Number: _____ Relationship: _____
How did you hear about our office? _____
Who may we thank for referring you to this office?_____
_____

Insurance Coverage (past and present)

Are you currently under the care of a home health aide? YES / / NO / /

NOTE: If you are receiving HOME HEALTH services now or in the future while still coming to this office, Medicare will not cover your services here and you will be responsible for all non-covered charges.

Have you had any Chiropractic or Physical therapy services this calendar year? *YES / / NO / /*

Current Health Condition

Current Complaint(s): _____
Other doctors seen for this condition? ☐ Yes ☐ No Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has the condition occurred before? Yes ☐ No ☐
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: _____
Date of Accident: _____Time of Accident: _____
What happened?_____
What aggravates your condition? ☐ Sleeping on the injured side ☐ Bending your elbow ☐ Straightening your elbow
☐Gripping/fisting with you hand ☐ Resting your elbow on a tabled
What relieves your condition? ☐ Bed Rest ☐ Ice ☐Heat ☐ Medication
☐ Other:_____
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better
Character of Pain: ☐ Sharp ☐Dull Ache ☐ Pins & Needles ☐ Numb ☐ Constant ☐ Burning

☐

Does the pain radiate anywhere? ☐ No ☐ Forearm or hand (L or R)

Other:_____

When does it hurt? ☐ Morning ☐ Evening ☐ It wakes me up at night Other:_____

Please describe how it feels when this problem is at its worse: _____

_____

Place an X on the grade to indicate the severity of your pain:

INITIALLY:	***No Pain*** **0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10(excruciating Pain)**
NOW (Average):	***No Pain*** **0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10(excruciating Pain)**

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:

Your ability to work? _____

Your ability to enjoy your family or your social time? _____

Your ability to enjoy your hobbies or sports? _____

At its worst, how old does this problem make you feel?_____

Have you had X-rays/ MRIs/ CT scans taken in the last six months? NO. If yes, where?:_____

Send us /bring your reports prior to or on the day of your appointment.

Past Health History

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia

☐ Other: _____

Orthopedic Surgeries/Injuries: 1.Head:_____Neck:_____

2. Upper Extremity: _____

3. Back: _____

4. Lower Extremity: _____

Previous: Motor Vehicle Accidents: ☐ _____ Work Injuries: ☐ _____

Hospitalization (other than above):_____

_____

Past Treatment History

Chiropractic Care/ Physical Therapy:

Have you ever had **Chiropractic Care** or **Physical Therapy** (circle one or both if yes)? **NO**

If Yes, **When**? _____ **Where**? _____

For what condition(s)?_____

Results: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Chiropractic or Physical Therapy Technique used: _____

Medical Doctor:

Name:_____ Telephone:_____

Address: _____

Date of Last Appointment:_____ Date of Last Physical: _____

Past Family History

Please indicate any health issues that are present in your family and that you suffer from too:

Parents:_____

Siblings: _____

Grandparents: _____

Medication and Supplement History

If you will be providing us with a written or typed list, do not complete the table below.

Medication Name	Dosage	Frequency	When did you start taking

Supplement Name	Dosage	Frequency	When did you start taking

Would you be interested in using vitamin supplements customized for your particular needs and/or to help counter-act the side-effects of your medications? ____ YES____ NO

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following you have had in the past six months:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black/Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

☐ **Vision Problems**
- ☐ Dental Problems
- ☐ Sore Throats
- ☐ Ear Aches
- ☐ Hearing Difficulties
- ☐ Stuffed Nose

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps

Check any of the following diseases you have had:
- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema

General
- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Significant Weight Loss

Females Only

When was your last period?

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

_____

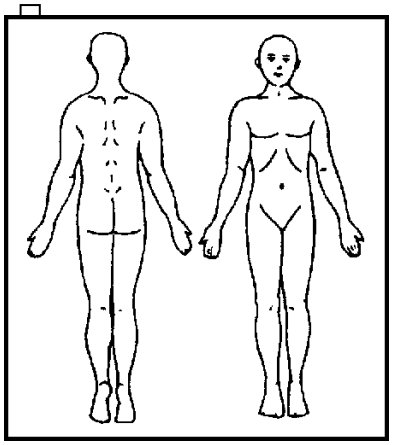
Male / Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Lifestyle Stress Levels
- ☐ High
- ☐ Moderate
- ☐ Very Little

Intake
- ☐ Coffee
- ☐ Tea
- ☐ Alcohol:___glasses/week
- ☐ Cigarettes: __/wk, for __/years
- ☐ White Sugar
- ☐ StreetDrugs:_____

Satisfaction with Diet
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Dissatisfied

Do you have a regular exercise program?
- ☐ Yes, Frequency:__/wk
- ☐



☐ No

Please outline on the diagram the area ofyour discomfort and any radiation of pain.

Revised Wednesday, May 17, 2017

COMPENSATION FOR SERVICES

In consideration of services rendered by the physicians at Active Lifestyles W & P ctr, which may include, but not be limited to, chiropractic care, acupuncture, physical therapy, massage therapy, strength training protocols/programs, or nutritional therapy I recognize that I am responsible for the fees associated with my care.

I understand that my insurance coverage may not cover all my charges and therefore I will be required to cover any gap created. A health insurance policy is an agreement between a policyholder and an insurance company and any disagreement regarding coverage must be determined between the parties. Active Lifestyles W& P ctr is therefore not responsible for settling policy disputes. Our office will be responsible for preparing notes, billing receipts and informal reports as needed to aid in insurance payment/reimbursement.

BENEFITS, RISKS, ALTERNATIVES

There are many approaches to health care. You are here today seeking our expertise in the way we approach health issues and you can be assured that your case will be managed to the best of our ability. The benefits of chiropractic care, acupuncture, physical therapy, massage therapy, strength training, and nutritional therapy are well documented in research. Although there can be great benefits inherent in any of the above modalities, the patient must also be informed that there may be risks involved as well. Those risks, although in our opinion minimal, may manifest themselves in post therapy soreness/stiffness/tenderness, sprains/strains, dislocations, fractures, disc injuries, strokes, allergic reactions. Your alternatives may include; no care, allopathic care, naturopathy, acupuncture, etc. It is impossible for the doctor to foresee every complication or risk that may be possible. You are encouraged to ask your doctor any questions you may have regarding any therapy proposed.

Although the human organism has a biological framework similar from one to the next, each individual is unique. Results may therefore vary. No guarantee of improvement or success can be made.

For pregnant females: In the event radiographs are recommended you are advised to inform the doctor and/or radiologist of the date you began your last period and/or pregnancy.

We try our best to get you well, but like any good relationship, cooperation and communication is a must. We therefore ask you:
1. Respect the appointment time given to you and call 24 hours ahead (M-F) of your appointment prior to canceling.
2. Follow the recommendations given to you with respect to exercise and activity levels.
3. Communicate all concerns and problems you may encounter with treatment at the next visit.

Witnessed by my signature below, I hereby certify that I am above the age of 18 and or emancipated, and have read the above in its entirety, recognize/agree to its content and hereby **CONSENT FOR TREATMENT** today and all future visits.

My Printed Name _____My Signature_____

Witnessed By _____ Date _____

Regular Fee Schedule (FOR THE MOST COMMON PROCEDURES ONLY)

Code	CPT	Description	Fee
Physical Therapy			
PT Eval 3	97163	Evaluation level 3	$125
PT Eval 2	97162	Evaluation Level 2	$80
PT Eval 1	97161	Evaluation Level 1	$75
PT ReEval	97164	Re-evaluation	$80
M-Ther	97140	Manual Therapy 1+ regions	$47.04 (per 15 min.)
Chiropractic			
OV5	*99205*	Office visit level 5	$436.82
OV3	*99203*	Office visit level 3	$228.60
OV1	99201	Office visit level 1	$91.16
SM	98940	Spinal manipulation 1-2 regions	$56.98
SM3	98941	Spinal manipulation, 3-4 regions	$84.44
SM5	98942	Spinal Manipulation, 5 regions	$108.58
MX1	98943	Manipulation Extraspinal, i.e. Extremities	$57.82
Therapies used in Chiropractic and Physical therapy (per 15 minutes)			
Gait	97116	Gait Training Therapy	$44.52
THER-EX	97110	Therapeutic Exercise	$49.98
NEURO	97112	Neuromuscular re-education	$51.46
THER-ADL	97530	Therapeutic Activities of daily living	$52.00
Modalities used in Chiropractic and Physical therapy (per area)			
E-STIM	G0283	Electrical Stimulation Therapy	$21.68
Hot/Co	97010	Hot/cold pack therapy	$13.08
US	97035	Ultrasound Therapy	$21.60
Other services/ equipment usually not covered by Insurance			
Elect	A4556	Electrodes for Therapy (4)	$10.00
Ex-band	A9300	Exercise Band	$12.00
NUT-AD	97802	Medical Nutritional Advice, initial	$150
NUT-F/U	99803	Medical Nutritional Advice follow-ups per 15 mins.	$40
LAZ	S8948	Laser treatment	$50

MISSED or Cancelled Appointment (less than a 24 hour notice) **$40 (cannot be billed to insurance)**

I understand that this is not a complete list of all the fees associated with this office and moreover, that insurance may not cover all these fees. Furthermore, I realize that I am ultimately responsible for paying all fees associated with my treatment here at Active Lifestyles Chiropractic, regardless if insurance pays for them or not. A complete fee schedule may be provided upon request.

_____ _____

(Signature) (Date)

_____ _____

(Office staff witness) (Date)

Revised May 17, 2017

ACTIVE LIFESTYLES WELLNESS & Performance CTR.

HIPAA Notification Protocol

I, _____, would like any and all communication with Active Lifestyles Wellness & Performance Center, LLC including, but not limited to, lab test results, diagnostic test results, appointment confirmation, financial account information, missed appointments, to be carried out in accordance with my instructions listed below. I further stipulate that a message may be left on the voicemail ready numbers written below.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Please provide your contact details in the order you wish our office to attempt to contact you:

_____ Email: _____

_____ Telephone _____

_____ Cell Ph: _____

_____ Business Ph: _____

In the event that any notification attempts made by Active Lifestyles W&P Center are unsuccessful, I grant them permission to have the information verbalized to the following people:

_____

_____

_____ _____

Patient Signature **Today's Date**

1715 37th Place, Third Floor

Vero Beach, Florida 32960

Telephone 772-978-7379

Fax 772-539-8515