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. We also make foot orthotics in this practice to help correct foot misalignments and restore normal pain free foot function. It is a comprehensive type practice and we encourage you to explore all we have to offer.

We strongly recommend you fill out all the forms attached and return them fully completed prior to your appointment. Unlike other offices, we are usually punctual and we therefore ask for your cooperation. Having the paperwork out of the way facilitates this. Also, we recommend you provide us with all imaging (X-Ray, MRI CT scan) reports in your possession relevant to your current complaint or have the office that has them forward it to us. If you are consulting us for nutrition, we ask for all relevant bloodwork results. If you are coming in for massage, realize that a timeframe is reserved for you. If you are late, this will cut into your massage time.

If you have been involved in a motor vehicle accident or in a workman's compensation accident and/or are currently or will be seeking legal help for your difficulties, please let us know prior to scheduling an appointment with us.

We look forward to serving you.

Best wishes of Health,
Your Healthcare Team at Active Lifestyles.

Active Lifestyles Wellness and Performance Center, LLC.
1715 37th Place, Third Floor, Vero Beach Florida, 32960.
www.activevero.com, info@activevero.com
Ph. No. 772-978-7379, Fax No: 772-539-8515

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

Personal History

Custom Foot Orthotics

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

Type of Work performing 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? _____

Current Health Condition

Have you ever worn orthotics before? No____ Yes____. If yes, ____custom-made or ____off the self. How old are they? ____years.
(Please bring them in along with at least 1 used pair of shoes).
Why are seeking orthotics: Comfort walking____ or comfort running ____?
If you walk or run for exercise, how many miles per week? ____
If you don't walk or run for exercise, are you looking for orthotics for dress/casual shoes? No ____Yes___.
Do you use any other devices to help you walk/run (cane, braces)? _____
Do your feet currently give you pain? No ____ Yes___. When? _____
Are you currently receiving treatment for your feet, hips or knees? No___ Yes___
What shoes do you wish your orthotics to fit? Dress____, Walking___, Running___.
Have you noticed yourself walking differently because of a past injury? No___ Yes___: Explain:_____
Do you notice that one of your legs appears longer? No___ Yes____: Which side? Left ___ Right ____.

Past Health History

Orthopedic Surgeries/Injuries: 1.Feet:_____Ankles:_____
2. Knees: _____
3. Hips: _____
4. Back: _____

Hospitalization (other than above): _____
_____

Medical History

Diabetes: Type_____ **Rheumatoid Arthritis: _____**
Polyneuropathy affecting Feet: _____ **Charcot Foot: _____**

Your Current Weight: ___lbs. **Shoe Size: ___** **Foot Width: Narrow, Medium, Wide**

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