ACTIVE CARE FAMILY CHIROPRACTIC

212 Main Street
Stevensville, MT
59870

Office: 406-777-1048
Fax: 406-777-1038
Email: acfchiro@gmail.com
www.activecaremt.com

Chiropractic Physician
Amy K. Berglund D.C.

Patient Name: ____

Date of Birth: _____/_____/___________ Age:___________

Welcome

The doctors and staff of Active Care Family 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. Please take your time to fill out this form so we can assist you as quickly and efficiently as possible.
I am also aware that there is a **24-hour cancellation policy**. If I am unable to keep my scheduled appointment I will provide a full 24 hour notice so that other patients may schedule at that time. At the discretion of the office I may be billed for my appointment if I do not show or provide sufficient notice of cancellation.

Patient identification

____
Name

____
Mailing address

____
City, State and Zip

______/______/____________
Social Security Number

(Please Circle): Male Female Marital Status: M, S, D, W

____
Name/nickname I prefer to be called

(_______)______________________________
Telephone (home)

(_______)______________________________
(Work)

Is it ok to call you at these numbers? Y / N

____
Email

Contact in case of emergency, Name: ______________________________________
Telephone # ______________________________________

Name of Parent of Minor Patient (if applicable): ______________________________

Who can we thank for referring you?______________________________________

____
Signature:

_____/_____/___________
Today's Date

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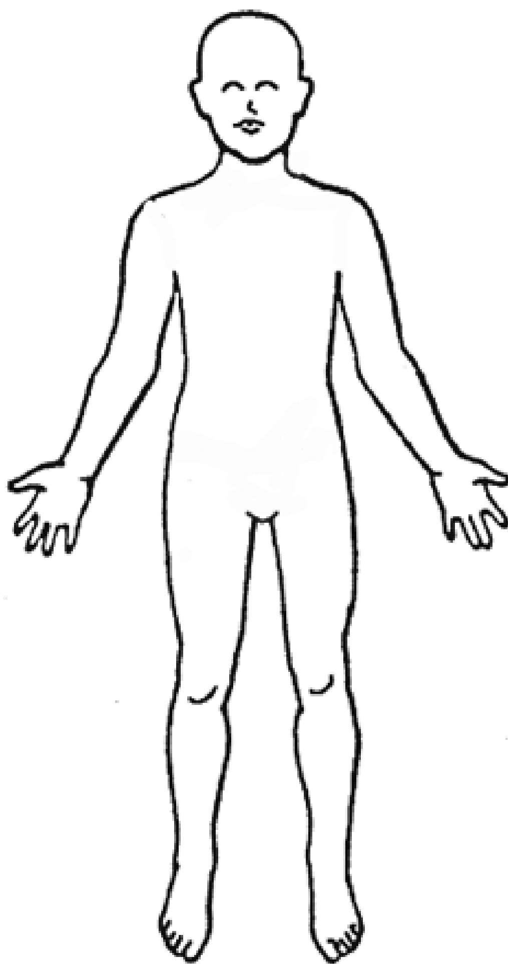
This drawing allows us to assess your current symptoms.

Where is your pain now?

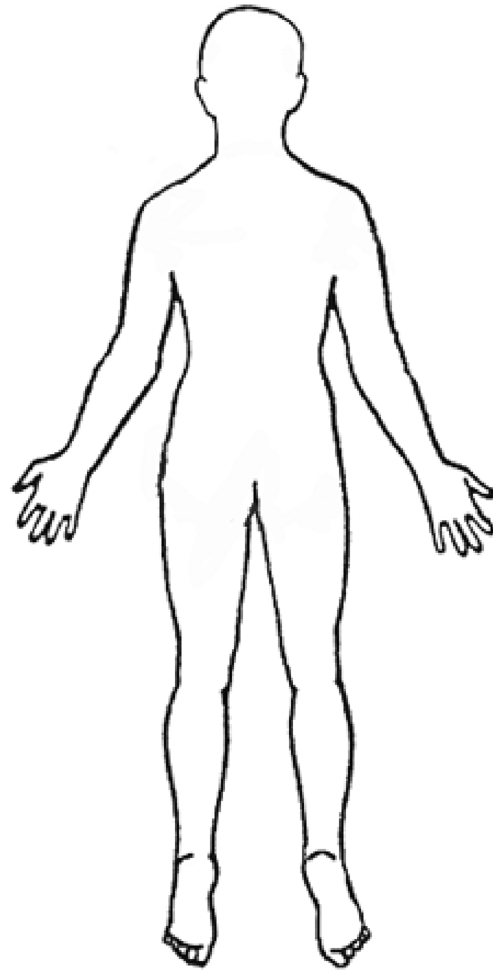
1. Mark the areas of your body where you feel the sensations described below, using the appropriate symbols.
2. Mark the areas of radiation, including all affected areas. Please circle

Aching	Numbness	Pins and Needles	Burning	Stabbing
* * * * *	====	000	XXX	//////

Right



Front



Back

Right

____
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Have you ever been to a Chiropractor before?

If so, when was your last visit and?

Name of your previous Chiropractor?

Major complaints and symptoms

- In the following section please be as specific as you can. Please ask the doctors for help if you need assistance in filling out this section

Are there any specific problems or complaints you wish us to address?

Can you tell us how they began and when you first noticed them.

Can you describe positions or activities which aggravate or flare up your condition.

Is this problem related to a work related accident or car accident? Y / N

Have you lost time at work due to this; please describe?

Have you ever had this or a similar condition in the past? Y / N

Are you currently under any other care related or unrelated to this condition? Y / N
Please describe the diagnosis, treatment types and the duration of care?

Have you visited a doctor within the last year for any medical care?

Name of your family physician.
Do we have permission to discuss your care with your family physician? Y / N

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Our goal is to provide you with the most in depth and complete care we can. This form is designed to gather a better over-all history of you current health. Please check the appropriate box. If you need assistance, please ask the doctors for help.

Past	Present	Past	Present	Past	Present
( )	( ) Headaches	( )	( ) High Blood Preassure	( )	( ) Asthma
( )	( ) Neck Pain	( )	( ) Heart Attack	( )	( ) Chronic Sinusitis
( )	( ) Upper Back Pain	( )	( ) Chest Pain	( )	( ) Diabetes Type 1:( ) Type 2: ( )
( )	( ) Mid Back Pain	( )	( ) Stroke	( )	( ) Excessive Thirst
( )	( ) Low Back Pain	( )	( ) Angina	( )	( ) Frequent urination
( )	( ) Shoulder Pain	( )	( ) Kidney Stones	( )	( ) Smoking/Tobacco Use
( )	( ) Elbow/Upper Arm Pain	( )	( ) Kidney Disorders	( )	( ) Drug/Alcohol Dependence
( )	( ) Wrist Pain	( )	( ) Bladder Infection	( )	( ) Allergies
( )	( ) Hand Pain	( )	( ) Painful Urination	( )	( ) Depression/Anxiety
( )	( ) Hi/Upper Leg Pain/Numbness	( )	( ) Loss of Bladder Control	( )	( ) Systemic Lupus
( )	( ) Knee/Low Leg Pain/Numbness	( )	( ) Prostrate Problems	( )	( ) Epilepsy
( )	( ) Ankle/Foot Pain/Numbness	( )	( ) Abnormal Weigh Gain/Loss	( )	( ) Dermatitis/Eczema/Rash
( )	( ) Jaw Pain	( )	( ) Loss of Appetite	( )	( ) HIV/AIDS
( )	( ) Joint Swelling/Stiffness	( )	( ) Abdominal Pain	**Females Only**	
( )	( ) Arthritis	( )	( ) Ulcer/Heart Burn/Gerd	( )	( ) Birth Control
( )	( ) Rheumatoid Arthritis	( )	( ) Hepatitis	( )	( ) Hormonal replacement
( )	( ) General Fatigue	( )	( ) Liver/Gall Bladder Disorder	( )	( ) Pregnancy
( )	( ) Muscular Incoordination	( )	( ) Cancer/Type/Stage	Other:	
( )	( ) Visual Disturbances	( )	( ) Tumor		

List all Prescription and over-the-counter medications, nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and the times you have been hospitalized:

Patient Signature: Date:

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FOR LOW BACK PAIN

The line below represents the intensity of low back pain.
Please mark an "X" at the position on the scale that indicates how much pain you feel in your low back <u>**at this time.**</u>

No Pain | Worst Pain Imaginable

FOR PAIN <u>OTHER THAN</u> LOW BACK PAIN

The line below represents the intensity of your pain <u>**other than low back pain.**</u> Please mark an "X" at the position on the scale that indicates how much pain you feel <u>**at this time.**</u>

No Pain | Worst Pain Imaginable

____
Signature:

_____/_____/________
Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice is effective as of April 4, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that a copy of the Privacy Practice notice has been made available to me for review and upon request a personal copy can be made for me.

Printed Name______________________________Signature______________________Date____________

If you are a minor, or if you are being represented by another party

Personal Representative_________________Personal Representative Signature___________

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 medical necessity for care. **In the event that full payment is not made within 120 days for any reason, you must understand that you are responsible to make payment in full. By signing I acknowledge that I am responsible for charges not paid by my insurance carrier. All past due accounts submitted for collection will be subject to collection fees and/or attorney's fees.**

Name of Insurance__________________________ Member ID:____________________________

Group #:________________________________ Employer_______________________________

Subscriber Name:__________________________ Subscriber DOB:_______________________