Full Name: _____ Today's Date: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Language: ___English Other: _____ How do you prefer we contact you? ___Home ___Cell ___Email

Home Phone: _____ Cell: _____ Email: _____

Race: __White __Black/African Am __Hispanic/Latino __Am Indian/Alaska Native __Asian /Pacific Islands __Decline Answer

Sex: M / F Ethnicity: __Hispanic/Latino __Non-Hispanic/Latino __Other:_____ __Decline to answer

Marital Status: S/M / D/ W / Partner # of Children _____

In Case of Emergency Contact:_____ Relationship:_____ Best Contact: _____

How did you hear about Active Balance Spine & Sports Care?_____

Whom may we thank for referring you?_____ What Struck you as key:_____

Primary Care Physician: _____ Office Phone: _____

PLEASE CHECK ALL OF THE SYMPTOMS THAT APPLY: (P=PAST / C=CURRENT)

P / C General

__/__ Headache
__/__ Facial Pain
__/__ Fever
__/__ Blurred Vision
__/__ Dizziness
__/__ Forgetfulness
__/__ Confusion
__/__ Head Pressure
__/__ Wheezing
__/__ Allergies
__/__ Teeth Grinding
__/__ Neck Pain
__/__ Movement Loss
__/__ Convulsions
__/__ Arm Numbness
__/__ Arm Pain
__/__ Arm Tingling
__/__ Chest Pressure
__/__ Chills
__/__ Fainting
__/__ Leg Numbness
__/__ Leg Pain
__/__ Leg Tingling
__/__ Weight Loss

Reproductive

If pregnant, due date:

_____

__/__ Cramps
__/__ Yeast Infections
__/__ Irregular Cycle
__/__ Painful Periods
__/__ Hemorrhaging
__/__ Difficulty Getting Pregnant
__/__ Miscarriages
__/__ Breast Lump
__/__ Ovarian Problem
__/__ Uterine Problem
__/__ Cancer

P / C EENT

__/__ Failing Vision
__/__ Eye Pain
__/__ Eye Disease
__/__ Hearing Loss
__/__ Earache
__/__ Ear Ringing
__/__ Hay Fever
__/__ Excessive Thirst
__/__ Dry Mouth
__/__ Sore Throat
__/__ Lump in Throat
__/__ Swallowing Pain
__/__ Difficult Swallowing
__/__ Thyroid Problem

Urinary

__/__ Freq/Urgent Urination
__/__ Painful Urination
__/__ UTIs
__/__ Kidney Infection
__/__ Kidney Disease
__/__ Incontinence
__/__ Kidney Stone
__/__ Prostate Disease
__/__ Surgeries/Lifts

Skin

__/__ Rash
__/__ Bruise Easily
__/__ Slow Healing Wound
__/__ Hives
__/__ Dermatitis
__/__ Prone to Infection
__/__ Itching
__/__ Skin Malignancies

P / C Respiratory

__/__ Do/did you Smoke
__/__ Difficulty Breathing
__/__ Chronic Cough
__/__ Unsteady Voice
__/__ Spitting Up Blood
__/__ Easily Winded

Cardiovascular

__/__ Rapid Heart Beat
__/__ Irregular Heart Beat
__/__ Pacemaker
__/__ High Blood Pressure
__/__ Low Blood Pressure
__/__ Pain Over Heart
__/__ Ankle Swelling
__/__ Cold Hands
__/__ Cold Feet
__/__ Leg Cramps
__/__ Cardiac Surgery
__/__ High Cholesterol
__/__ High Triglycerides
__/__ Stroke

Joint/Muscle

__/__ Neck Pain/Stiffness
__/__ Low Back Pain
__/__ Joint Swelling/Pain
__/__ Muscle Weakness
__/__ Tremors
__/__ Knee Pain
__/__ Shoulder/Arm Pain
__/__ Mid Back Pain
__/__ Elbow/Hand Pain
__/__ Inflexibility
__/__ Nerve Pain that travels

P / C Gastrointestinal

__/__ Poor Appetite
__/__ Nausea
__/__ Vomiting
__/__ Constipation
__/__ Colitis/ IBS
__/__ Diarrhea
__/__ Liver Disease
__/__ Stomach Pain
__/__ Gallbladder Disease
__/__ Ulcers
__/__ Bloody Stool
__/__ Hemorrhoids
__/__ Acid Reflux /GERD
__/__ Polyps
__/__ Esophageal Erosion
__/__ Loss of Bowel Control
__/__ Very Thirsty
__/__ Very Hungry
__/__ Abdominal Pain
__/__ Abdominal Hernias
__/__ Severe Bad Breath

Illnesses

__/__ Cancer
__/__ Chemical Dependency
__/__ Diabetes
__/__ Multiple Sclerosis
__/__ Osteoporosis
__/__ Polio
__/__ Psychiatric Illness
__/__ Epilepsy
__/__ Rheumatoid Arthritis
__/__ Tumors/Growths
__/__ Melanoma
__/__ Prosthesis
__/__ Chronic Fatigue
__/__ RSD / CRPS

Patient Name:_____ **Date:** _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began them.

Drug Type	Drug Name	Dosage & Frequency	Date Started
Antacids			
Antibiotics			
Antidepressants			
Anti-inflammatory			
Arthritis Drugs			
Behavioral Modification			
Blood Pressure Lowering			
Cholesterol Lowering			
Hormone Replacement			
Oral Contraceptives			
Other			

FAMILY HISTORY: Identify any conditions that you or any of your family members have now or have had in the past: M=Mother, F=Father, S=Siblings, X=Self, MGM=Maternal Grandmom, MGF=Mat Granddad, PGM=Paternal Grandmom, PGF=Pat Granddad)

_____Alcoholism/Drug Abuse _____Eczema _____Miscarriage(s) _____Tumor(s) _____Stroke _____ Marfan's
_____Deep Vein Thrombosis _____Cancer _____Pneumonia _____Cold Sores _____Mumps _____ Hypertrophic
_____Detached Retina _____Goiter _____Diabetes _____Epilepsy _____Polio Cardiomyopathy
_____Diverticulitis/IBS _____Anemia _____Emphysema _____Pleurisy _____Heart Disease
_____Rheumatic Fever _____Ulcers _____Hepatitis _____HIV/AIDS _____Vaccine Reaction
_____Seizures/Fainting _____Gout _____Other_____

SUPPLEMENTS: List vitamins/supplements/herbs/homeopathics_____
_____ Who recommended them?_____

HABITS: Heavy Moderate Light None

Alcohol ☐ ☐ ☐ ☐
Caffeine ☐ ☐ ☐ ☐
Drugs ☐ ☐ ☐ ☐
Soda ☐ ☐ ☐ ☐
Stress ☐ ☐ ☐ ☐

Exercise Type _____ Length of Workout_____

Exercise 5-7x/wk ☐ 3-5x/wk☐ 1-3x/wk☐ _____
Sleep 8+ hrs☐ 7-8 hrs☐ 6-7hrs ☐ 5-6 hrs☐ <5hrs ☐
Meals 5+ ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐
Water 64+oz ☐ 32-64oz☐ 16-32oz☐ <8oz ☐
Type of Stress: Physical / Emotional / Chemical _____

Do you smoke (cigarette or cigar)? __Never __Former Smoker __Current/Every Day Smoker __Current Some Day Smoker

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Other_____

Work/ Primary Daily Activity: ☐ Sitting ☐Standing ☐Computer/Phone (ergonomic /not ergonomic) ☐Light Labor ☐ Heavy Labor

INJURIES/SURGERIES you have had: Description Date

Car Accidents 1. _____ _____
2. _____ _____
Falls (down stairs, on ice, etc) _____ _____
Have you ever hurt your head? _____ _____
Sprains/Dislocations/Broken Bones_____ _____
Surgeries_____

Patient Name: _____ Date: _____

ALLERGIES: Please check and list all allergies and describe reaction

Medication:_____

Food: _____

Substance /Environmental: (this may include lotions, etc) _____

Informed Consent for Chiropractic Treatment

I request and consent to diagnostic tests and procedures, and chiropractic treatment or management of my condition, including physiotherapy. This treatment may be performed by Robin Linster, DC and/or other licensed Doctors of Chiropractic serving as a backup for Dr. Linster.

Chiropractic services or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment and associated physiotherapy procedures carry with them some risks. Unlike many such medical procedures, the serious risks associated with the chiropractic are extremely rare.

Some of these risks include but are not limited to:

No improvement of symptoms or pain	Increased symptoms and pain	Sprains/ Strains
Dislocations / Fractures	Muscle Soreness	Burns or frostbite (physiotherapy)

In extremely rare cases there have been reported complications of stroke associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary medical doctors before their stroke. adjustment.

I have had the opportunity to discuss with Dr. Linster the nature and purpose of my chiropractic exam and treatment, the risks and benefits of my care, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I _____, patient or guardian of patient, have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my current condition.

_____ _____ _____

Practice Member's Signature Date Guardian's Signature

Our Patient Health Information Policies

1. The patient understands and agrees to allow Active Balance Spine and Sports Care to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care.
2. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written permission.
3. The patient or guardian consents to use patient's name for the purpose of Welcomes, Referrals , Testimonials, Kids Photo Boards, Birthdays, and etc strictly for special acknowledgments. _____ (Initial)

I have read and understand how my (or my dependent's) PHI will be used and agree to these policies and procedures.

_____ _____

Practice Member's 's (or Guardian) Signature Date

Patient Name:_____ **Date:** _____

Our Office Policy on Missed Appointments: We understand that situations unfold so that appointments must be cancelled. However, you will be responsible for office visit charge of $57 for appointments made but not cancelled.

Our Office Policy on Returned Checks: There will be a $30 charge for returned checks.

I have read and fully understand the above statements _____ _____

Patient's (or Guardian) Signature Date

Insurance: I understand that while Linster Chiropractic will accept assignment of benefits when possible, ultimately, my coverage is a contract between me and my insurance carrier. The insurance industry has limitations on benefit coverage; maintenance is generally not included. For this reason, payment is expected at the time of service unless other arrangements are made. **If assignment is accepted, it is for intensive and reconstructive phases of care only.** Where Dr. Linster is a participating provider, I will pay only deductibles/copays and coinsurance as my carrier instructs. I understand there may be a difference between the treatment plan Linster Chiropractic provides and my coverage. This will be explained to me as need arises and I will acknowledge with initials on a separate form.

Assignment and Release: I, the undersigned certify that I (or my dependent) have insurance coverage with the above named company and assign directly to Dr. Robin Linster all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Insurance Co_____ Subscriber's Name_____ DOB:_____

Group #_____ ID# _____ Relationship to Patient_____

Mailing Address: _____

Is patient covered by additional insurance? □Y □N

Insurance Co_____ Subscriber's Name_____ DOB:_____

Group #_____ ID# _____ Relationship to Patient_____

Mailing Address: _____

_____ _____ _____

Patient's Signature Date Guardian's Signature

All of this being said, it is my sincere desire to serve all who want to receive care. I invite you to become an active participant in your own health care and to explore the expanded concepts of health that are presented. I am committed to building bridges of knowledge and supporting your journey in wellness.