2215 Garden Street
Titusville, FL 32796

~ Welcome to ~

Active Spine Center, LLC

Phone: 321-268-2210
Fax: 321-325-2100

Patient Title: (check one) ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Prof ☐ Rev

First Name:_____Nick Name:_____
Last Name:_____Middle Name:_____Suffix:_____
Address 1:_____
Address 2:_____
City:_____State:_____**Zip Code:**_____
Primary Phone:_____Secondary Phone:_____
Mobile Phone:_____ Best Contact Method: ☐ Phone ☐ Email
Home Email:_____Work Email:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Date of Birth:_____Age:_____ **Gender:** ☐ Male ☐ Female ☐ Unspecified

Marital Status: ☐ Single ☐ Married ☐ Other SSN:_____

Employment Status: ☐ Employed ☐ FT Student ☐ PT Student ☐ Self Employed ☐ Retired ☐ Other

Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian/Alaska Native
☐ Filipino ☐ Asian Indian ☐ Japanese ☐ Native Hawaiian/Pacific Islander
☐ Chinese ☐ Vietnamese ☐ Samoan ☐ Guamanian or Chamorro
☐ Korean ☐ Other _____ ☐ I choose not to specify

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ I choose not to specify

Multi-Racial: ☐ Yes ☐ No ☐ Unknown Preferred language:_____

Do you have children? ☐ Yes ☐ No How many:_____

Verification Question: (choose one)

☐ In what city were you born? ☐ What is the name of your favorite pet?
☐ What high school did you attend? ☐ What street did you grow up on?
☐ What is your favorite color? ☐ What was the make of your first car?
☐ What is your favorite movie? ☐ When is your anniversary?

Verification answer:_____

Other Health Care Providers (ex: Primary care physician)

Provider Name:_____
Provider Type:_____
City & State:_____
Provider Phone:_____
Seen for primary problems? ☐ Yes ☐ No

Provider Name:_____
Provider Type:_____
City & State:_____
Provider Phone:_____
Seen for primary problems? ☐ Yes ☐ No

Employment Information

Occupation:_____
Employer Name:_____
Address:_____
City/State/Zip:_____
Work Phone:_____
May we call your mobile phone at work? ☐ Yes ☐ No
May we call your work phone? ☐ Yes ☐ No

Have you ever consulted a chiropractor before?
☐ Yes ☐ No
If yes, who:_____
Last visit:_____
Referred by:_____

Problem Areas

Describe your problem: ☐ Old Injury ☐ New Injury ☐ Chronic Pain ☐ Wellness ☐ Emergency

_____

_____

_____

On a scale of 0 – 10, circle the intensity: Lowest – 0 1 2 3 4 5 6 7 8 9 10 – Highest

How did your problem begin: _____

_____

_____

Date problem started:_____

How often do you experience symptoms:_____

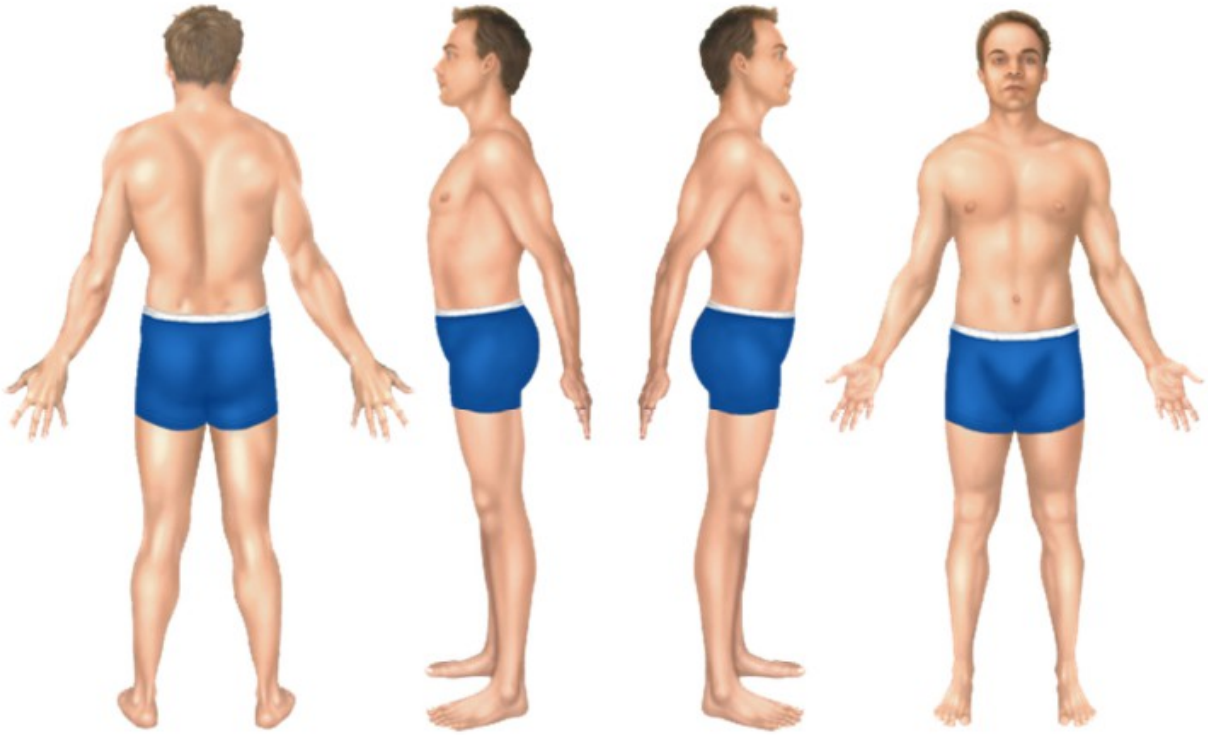
Nature of your symptoms:

☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Tingling ☐ Cramping
☐ Sharp ☐ Burning ☐ Deep ☐ Radiating ☐ Stabbing

What have you done to relieve the symptoms:

☐ Prescription medication ☐ Over the counter drugs ☐ Surgery ☐ Chiropractic ☐ Ice
☐ Homeopathic Remedies ☐ Physical Therapy ☐ Massage ☐ Acupuncture ☐ Heat

Please mark the involved areas!



Medications

Name:_____ Comments:_____
Dosage:_____ _____
Start Date:_____ _____
Obtained: ☐ Over the counter ☐ By prescription
Prescribed by:_____

Name:_____ Comments:_____
Dosage:_____ _____
Start Date:_____ _____
Obtained: ☐ Over the counter ☐ By prescription
Prescribed by:_____

Name:_____ Comments:_____
Dosage:_____ _____
Start Date:_____ _____
Obtained: ☐ Over the counter ☐ By prescription
Prescribed by:_____

Nutritional Supplements

Name:_____ Reason for Taking:_____
Start Date:_____ _____
Manufacturer:_____ Comments:_____
Quantity:_____ _____
Frequency:_____ _____
Taken with water: ☐ Yes ☐ No

Name:_____ Reason for Taking:_____
Start Date:_____ _____
Manufacturer:_____ Comments:_____
Quantity:_____ _____
Frequency:_____ _____
Taken with water: ☐ Yes ☐ No

Name:_____ Reason for Taking:_____
Start Date:_____ _____
Manufacturer:_____ Comments:_____
Quantity:_____ _____
Frequency:_____ _____
Taken with water: ☐ Yes ☐ No

Allergies

Name:_____ Comments:_____
Medication related: ☐ Yes ☐ No _____
Symptom:_____ _____
Start Date:_____

Name:_____ Comments:_____
Medication related: ☐ Yes ☐ No _____
Symptom:_____ _____
Start Date:_____

Personal Medical History

Illnesses

Illness:_____ Illness:_____
Start Date:_____ Start Date:_____
End Date:_____ End Date:_____

Surgeries

Surgery:_____ Surgery:_____
Date:_____ Date:_____

Hospitalizations

Reason:_____ Reason:_____
Date:_____ Date:_____
Duration:_____ Duration:_____

Injuries

Injury:_____ Injury:_____
Date:_____ Date:_____

Family Medical History

Illness:_____ Illness:_____
Relation:_____ Relation:_____
Age of onset:_____ Age of onset:_____

Illness:_____ Illness:_____
Relation:_____ Relation:_____
Age of onset:_____ Age of onset:_____

Review of Body Systems

Do you have or have you had ANY of the following diseases, medical conditions or procedures?

Musculoskeletal □ No Issues

Osteoporosis: □ Have □ Had □ No
Scoliosis: □ Have □ Had □ No
Back Problems: □ Have □ Had □ No
Knee Injuries: □ Have □ Had □ No
Shoulder Problem: □ Have □ Had □ No
TMJ Issues: □ Have □ Had □ No
Arthritis: □ Have □ Had □ No
Neck Pain: □ Have □ Had □ No
Hip Disorders: □ Have □ Had □ No
Foot/Ankle pain: □ Have □ Had □ No
Elbow/Wrist Pain: □ Have □ Had □ No
Poor Posture: □ Have □ Had □ No

Neurological □ No Issues

Anxiety: □ Have □ Had □ No
Headaches: □ Have □ Had □ No
Pins & Needles: □ Have □ Had □ No
Depression: □ Have □ Had □ No
Dizziness: □ Have □ Had □ No
Numbness: □ Have □ Had □ No

Cardiovascular □ No Issues

High Blood Pressure: □ Have □ Had □ No
High Cholesterol: □ Have □ Had □ No
Angina: □ Have □ Had □ No
Low Blood Pressure: □ Have □ Had □ No
Poor Circulation: □ Have □ Had □ No
Excessive Bruising: □ Have □ Had □ No
Heart Attack/Stroke: □ Yes □ No

Respiratory □ No Issues

Asthma: □ Have □ Had □ No
Emphysema: □ Have □ Had □ No
Shortness of Breath: □ Have □ Had □ No
Sinus Problems: □ Have □ Had □ No
Apnea: □ Have □ Had □ No
Hay Fever: □ Have □ Had □ No
Pneumonia: □ Have □ Had □ No

Constitutional □ No Issues

Fainting: □ Have □ Had □ No
Poor Appetite: □ Have □ Had □ No
Sudden Weight Gain/Loss: □ Have □ Had □ No
Low Libido: □ Have □ Had □ No
Fatigue: □ Have □ Had □ No
Weakness: □ Have □ Had □ No

Digestive □ No Issues

Anorexia/Bulimia: □ Have □ Had □ No
Food sensitivities: □ Have □ Had □ No
Constipation: □ Have □ Had □ No
Ulcer: □ Have □ Had □ No
Heartburn: □ Have □ Had □ No
Diarrhea: □ Have □ Had □ No

Sensory □ No Issues

Blurred Vision: □ Have □ Had □ No
Hearing Loss: □ Have □ Had □ No
Loss of smell: □ Have □ Had □ No
Ringing in Ears: □ Have □ Had □ No
Chronic Ear Infection: □ Have □ Had □ No
Loss of Taste: □ Have □ Had □ No

Integumentary □ No Issues

Skin Cancer: □ Have □ Had □ No
Eczema: □ Have □ Had □ No
Hair Loss: □ Have □ Had □ No
Psoriasis: □ Have □ Had □ No
Acne: □ Have □ Had □ No
Rash: □ Have □ Had □ No

Endocrine □ No Issues

Thyroid Issues: □ Have □ Had □ No
Hypoglycemia: □ Have □ Had □ No
Swollen Glands: □ Have □ Had □ No
Immune Disorders: □ Have □ Had □ No
Frequent Infection: □ Have □ Had □ No
Low Energy: □ Have □ Had □ No

Genitourinary □ No Issues

Kidney Stones: □ Have □ Had □ No
Bedwetting: □ Have □ Had □ No
Erectile Dysfunction: □ Have □ Had □ No
Infertility: □ Have □ Had □ No
Prostate Issues: □ Have □ Had □ No
PMS Symptoms: □ Have □ Had □ No

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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

Smoking History

Smoking Status: ☐ Never smoker ☐ Current smoker ☐ Former smoker

Years smoked:_____ Packs a day:_____

How long since you stopped:_____

Interest in quitting on a scale of 0-10: Lowest – 0 1 2 3 4 5 6 7 8 9 10 – Highest

Social History

Consumption

How much alcohol do you drink daily:_____

How many cups of coffee do you drink daily:_____

How much soda pop do you drink daily:_____

How much water do you drink daily:_____

How much do you depend on pain relievers:_____

Do you use recreational drugs: ☐ Yes ☐ No

Stress Information

How much physical stress are you under: Not much – 0 1 2 3 4 5 6 7 8 9 10 – A lot

How much emotional stress are you under: Not much – 0 1 2 3 4 5 6 7 8 9 10 – A lot

What are the major stressors in your life:_____

Sleeping Information

How many hours do you sleep per night:_____

What is your preferred sleeping position:_____

What type of mattress & pillow do you have:_____

How old are your mattress & pillow:_____

Healthy Eating & Exercise Information

How much regular exercise do you perform:_____

Rate your healthy eating habits: Not healthy – 0 1 2 3 4 5 6 7 8 9 10 – Healthy

Typical eating habits: ☐ Skip Breakfast ☐ 2 meals per day ☐ 3 meals per day

☐ Snacking between meals

What would be the most significant thing that would improve your health:

_____

_____

What additional health goals do you have:

_____

_____

Acknowledgments

Check the boxes below

Chiropractic Care:	☐	I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxaiton. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named diseases or entity.
Privacy Verification:	☐	I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. Grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Permission to Contact:	☐	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Payment Verification:	☐	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
X-ray Verification: *(females only)*	☐	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks. Date of last menstrual period:_____
General Verification:	☐	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If I do not understand the nature of chiropractic treatment and related therapies that are used in this office, I will discus it with the Doctor to have my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to treatment.

Signature:_____Date:_____

Guardian/Parent Signature:_____Date:_____

Doctor's Name: Steven Smith, DC / Joanielee Kriz, DC

Doctor's Signature:_____Date:_____

DO NOT SIGN THIS DOCUMENT UNTIL YOU FULLY UNDERSTAND THE NATURE OF CARE IN OUR OFFICE. YOU MAY DISCUSS THE DOCUMENT WITH YOUR DOCTOR. YOU ARE ENCOURAGED TO SIGN IN THE PRESENCE OF THE DOCTOR SO THAT ALL QUESTIONS CAN BE ANSWERED.