

## TERMS OF ACCEPTANCE

**AS USED IN THESE DOCUMENTS, THE TERMS "WE," "OUR" AND/OR "US" REFERS TO HOLLINGSWORTH CHIROPRACTIC & ACUPUNCTURE**

### EXPLANATION OF SERVICES

Routine activities regularly cause subluxations of the spine. These subluxations, otherwise known as joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause decreased joint motion, pain, discomfort and/or a lessening of the body's ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

Our primary focus is providing patients with a pathway towards better health through ongoing chiropractic treatment consisting of maintenance and preventative care. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don't do:

### WHAT WE DO

- We provide the public with an affordable and convenient portal of entry to wellness through routine chiropractic care often resulting in better function, improved joint motion, and a healthier, more active lifestyle.
- We accomplish our goal through the gentle application of a targeted movement where and when indicated by licensed doctors of chiropractic to improve motion of the body's spinal column and extremities. This is commonly referred to as an adjustment or manual manipulation.

### WHAT WE DON'T DO / LIMITATION OF SERVICES

- We do not offer to treat any disease or condition other than joint dysfunctions associated with the spine and extremities.
- We do not accept or bill insurance, Medicare, and/or any third party carrier for payment.
- We do not have extensive diagnostic or on-site x-ray equipment, provide invasive testing/treatment or administer physiotherapies such as laser, electrical muscle stimulation or ultrasound.
- Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities.
- In the doctor's professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

### FINANCIAL RESPONSIBILITY

At the patient's discretion, payment options are available after the Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom they have insurance coverage.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Patient Printed Name)

All questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiropractic care provided to me at Hollingsworth Chiropractic & Acupuncture based upon these guidelines.

\_\_\_\_\_  
(Patient Signature) (Date)

### CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, \_\_\_\_\_ of \_\_\_\_\_ have read  
(Parent or Legal Guardian) (Child/(ren) Name)

and fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.

\_\_\_\_\_  
(Parent or Legal Guardian Signature) (Date)

**AS USED IN THESE DOCUMENTS, THE TERMS “WE,” “OUR” AND/OR “US” REFERS TO HOLLINGSWORTH CHIROPRACTIC & ACUPUNCTURE.**

**EXPLANATION OF SERVICES**

When a Medicare Eligible Patient seeks chiropractic health care here, it is essential for the patient to understand the services we provide.

Routine activities regularly cause subluxations of the spine. These subluxations, otherwise known as joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause decreased joint motion, pain, discomfort and/or a lessening of the body’s ability to function properly. Chiropractic focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

We ONLY provide maintenance care for Medicare Eligible Patients. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don’t do:

**WHAT WE DO**

- We provide the public with an affordable and convenient portal of entry to wellness through routine chiropractic care often resulting in better function, improved joint motion, and a healthier, more active lifestyle.
- We accomplish our goal through the gentle application of a targeted movement where and when indicated by licensed doctors of chiropractic to improve motion of the body’s spinal column and extremities. This is commonly referred to as an adjustment or manual manipulation.

**WHAT WE DON’T DO / LIMITATION OF SERVICES**

- We do not offer to treat any disease or condition other than joint dysfunctions associated with the spine and extremities.
- We do not accept or bill insurance, Medicare, and/or any third party carrier for payment.
- We do not have extensive diagnostic or on-site x-ray equipment, provide invasive testing/treatment or administer physiotherapies such as laser, electrical muscle stimulation or ultrasound.
- Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities.
- In the doctor’s professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

**FINANCIAL RESPONSIBILITY**

At the patient’s discretion, payment options are available upon request after the Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom they have insurance coverage.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Patient Printed Name)

All questions regarding the doctor’s objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept all chiropractic care provided to me at Hollingsworth Chiropractic & Acupuncture based upon these guidelines.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)

**CONSENT TO EVALUATE AND TREAT A MINOR CHILD OR PATIENT**

I, \_\_\_\_\_ of \_\_\_\_\_ have read and fully  
(Parent or Legal Guardian) (Child or Patient Name)

understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.

\_\_\_\_\_  
(Parent or Legal Guardian Signature)

\_\_\_\_\_  
(Date)

**NOTE: Medicare DOES NOT pay for Chiropractic Maintenance/Wellness Care that is provided at HOLLINGSWORTH CHIROPRACTIC & ACUPUNCTURE**

<b>Chiropractic Maintenance Care</b>	<b>Reason Medicare May Not Pay:</b> Spinal physical or manipulative treatment performed for Maintenance Care rather than restorative care is not a Medicare covered service.	<b>Estimated Cost per Visit:</b> <b>\$10 - \$45</b>
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**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Maintenance Care listed above.

**OPTIONS** Check only one box. We cannot choose an option for you.

**Option 1:** I want the Chiropractic Maintenance Care listed above. I understand the provider may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments made to you, less co-pays or deductibles. **By selecting this box we will refer you to another provider.**

**Option 2:** I want the Chiropractic Maintenance Care listed above, but do not bill Medicare. I understand the provider may ask to be paid now and I am responsible for payment. I cannot appeal if Medicare is not billed.

**Option 3:** I do not want the Chiropractic Maintenance Care listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay. **By selecting this box we will refer you to another provider.**

Signing below means that you have received and understand this notice. You also receive a copy.

**Additional Information: This ABN form is only good for up to one (1) year. This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/ TTY: 1-877-486-2048).**



\_\_\_\_\_  
(Patient or Legal Guardian Signature)

\_\_\_\_\_  
(Date)

**PATIENT INFORMATION**

Patient ID \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Gender M / F Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ W / C / H

Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Are you Medicare Eligible? Yes / No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? Yes / No

**How did you first hear about Hollingsworth Chiropractic & Acupuncture?**

Facebook / Instagram / Website / Other: \_\_\_\_\_

If you were referred by someone please tell us who so we may thank them.

\_\_\_\_\_



\_\_\_\_\_

(Patient or Legal Guardian Signature)

\_\_\_\_\_

(Date)

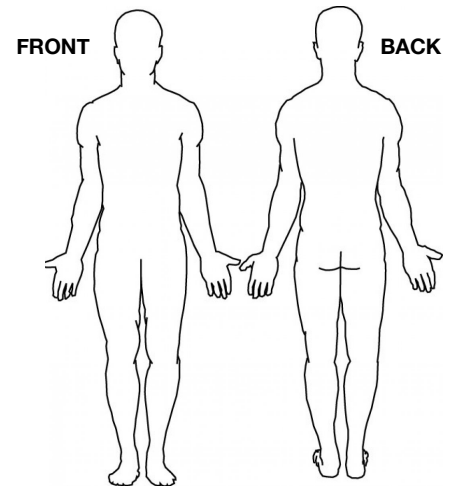
# PATIENT HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender M / F  
 Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Occupation \_\_\_\_\_ For how long? \_\_\_\_\_ yrs. \_\_\_\_\_ mos.

- Have you had chiropractic care before? Yes / No If yes, how recently? \_\_\_\_\_
- Reason for today's visit: (circle all that apply)  
 Pain / Discomfort / Stiffness / Maintenance Care / Recent Injury / Previous Injury / Other: \_\_\_\_\_
- When did your complaint(s) first begin? \_\_\_\_\_ 3b. Today, is the condition: Same / Better / Worse  
 Explain what helps and/or worsens the condition: \_\_\_\_\_

4. Where is/are your area(s) of complaint today?  Check all that apply	Rate pain and discomfort between 1-10  1 = minimal 10 = severe	Check off the type of Complaint							Frequency	
		Radiating	Sharp	Dull	Tingling	Numbness	Burning	Inflamed/Swollen	Constant	Intermittent
Headache/Migraine										
Neck										
Shoulder(s)										
Arm(s)										
Elbow(s)										
Wrist(s)										
Upper Back										
Middle Back										
Lower Back										
Hip(s)										
Sciatica										
Knee(s)										
Ankle(s)										
Other										

5. Use the figures below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



For Clinic Use Only: BP: \_\_\_\_\_ / \_\_\_\_\_  
 Arm: R / L

- Have you experienced this/these complaint(s) before? Yes / No if yes, when? \_\_\_\_\_
- Are you pregnant? Yes / No / N/A If yes, how many weeks? \_\_\_\_\_
- Are you **currently** experiencing any of the following: (Circle all that apply)  
 Nausea or vomiting / Rapid eye movement / Numbness on one side of the face or body / Fainting or lightheadedness / Dizziness  
 Difficulty walking / Difficulty speaking / Headache or neck pain / Difficulty swallowing / Double Vision  
 (If yes to any, please describe): \_\_\_\_\_

9. Current prescriptions or over-the-counter medications: \_\_\_\_\_

- PAST HISTORY: MUSCULOSKELETAL CONDITIONS** (please check all that apply)
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Headaches/Migraines                 | <input type="checkbox"/> Hip Pain/Discomfort   | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Neck Pain/Discomfort                | <input type="checkbox"/> Sciatica              | <input type="checkbox"/> Fused/Fixated Joints |
| <input type="checkbox"/> Shoulder Pain/Discomfort            | <input type="checkbox"/> Elbow Pain/Discomfort | <input type="checkbox"/> Herniated Disc       |
| <input type="checkbox"/> Upper Back Pain/Discomfort          | <input type="checkbox"/> Wrist Pain/Discomfort | <input type="checkbox"/> Joint Replacement    |
| <input type="checkbox"/> Middle Back Pain/Discomfort         | <input type="checkbox"/> Knee Pain/Discomfort  | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Low Back Pain/Discomfort            | <input type="checkbox"/> Ankle Pain/Discomfort | <input type="checkbox"/> Osteopenia           |
| <input type="checkbox"/> Inflammation/Swelling; where: _____ |  |   |

- OTHER CONDITIONS**
- |  |  |
|--|--|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Tumors              | <input type="checkbox"/> AIDS/HIV      |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Seizure Disorders   | <input type="checkbox"/> Hepatitis     |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Hernia        |
| <input type="checkbox"/> Allergies           |  |
| <input type="checkbox"/> Other _____         |  |

- Indicate if you have experienced any of the following and mark how recently.  
 Surgeries? Yes / No When? \_\_\_\_\_  
 Accidents/Broken Bones? Yes / No When? \_\_\_\_\_  
 Hospitalizations? Yes / No When? \_\_\_\_\_  
 If yes to any, list and describe \_\_\_\_\_

11. Family Health History: (circle all that apply) Cancer / Tumors / Stroke / Seizures / Diabetes / High Blood Pressure / Heart Disease

(Patient or Legal Guardian Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

# **INFORMED CONSENT**

## **INFORMED CONSENT TO CHIROPRACTIC CARE**

We provide adjustments or manual manipulations through the gentle application of a targeted movement where and when indicated by a licensed Doctor of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and a healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations and fractures. In addition:

1. While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:
2. There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result in injuries including paralysis.
3. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from Hollingsworth Chiropractic & Acupuncture.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
(Patient Printed Name)

\_\_\_\_\_  
(Patient or Legal Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness / Employee Signature)

\_\_\_\_\_  
(Date)

## **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY US, HOLLINGSWORTH CHIROPRACTIC & ACUPUNCTURE, INC. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this Notice, please contact Hollingsworth Chiropractic & Acupuncture.

### **Who Will Follow This Notice?**

1. Us, Hollingsworth Chiropractic & Acupuncture, Inc.
2. Doctors of Chiropractic who provide services to you at Hollingsworth Chiropractic & Acupuncture
3. All employees and subcontractors of Hollingsworth Chiropractic & Acupuncture

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive chiropractic treatment from us, a record of the treatment you receive is made. Typically, this record contains your treatment plan, your history and physical, any x-ray and test results that you provide to us, and billing record. This record serves as a:

1. Basis for planning your treatment;
2. Means of communication for or between Hollingsworth Chiropractic & Acupuncture doctors and staff, Hollingsworth Chiropractic & Acupuncture and your other health care providers, if any, that you wish us to share them with; and a
3. Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as “medical information”). It also describes your rights and our obligations regarding the use and disclosure of medical information.

### **OUR RESPONSIBILITIES We are required by law to:**

1. Maintain the privacy and security of your medical information;
2. Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
3. Abide by the terms of this notice; and
4. Notify you if we are unable to agree to a requested restriction.

### **The Methods in Which We May Use and Disclose Medical Information about You**

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1. **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your chiropractic treatment at this clinic. For example, we may share your information with your primary care physician or other specialists upon request.
2. **For Payment.** We will use and disclose medical information about you so that payment for the treatment you receive may be collected from you or another party.
3. **For Health Care Operations.** We may use and disclose medical information about you for our office operations. These uses and disclosures are necessary to run the clinic in an efficient manner and provide that all patients receive quality care. For example, your medical records may be used in the evaluation of services, and the appropriateness and quality of chiropractic treatment we provide. Chiropractic services will be provided in an open room where other patients are also receiving care. Other persons in the office may overhear some of your protected medical information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request. To the extent permitted by law, we may use cameras or other recording devices in our clinics. Any clinics having cameras or recording devices will have a notice posted at the clinic informing you of the use of such devices.
4. **For Contacting You.** We may use your address, phone number, e-mail and clinical records to contact you with notifications, text messages, birthday and holiday related messages, billing inquiries, information about treatment alternatives, or other health related information. If contacting you by phone, we may leave a message on your answering machine or voicemail.
5. **Appointment Reminders.** We may use and disclose medical information to remind you of an appointment, if applicable.
6. **As Required by Law.** We will disclose medical information about you when required to do so by federal or state laws or regulations.
7. **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
8. **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
9. **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official in response to a court order or subpoena.
10. **Electronic Disclosure.** We may use and disclose your medical information electronically. For example, your medical information is maintained on an electronic health record. If another provider requests a copy of your medical record for treatment purposes, we may forward such record electronically.

# NOTICE OF PRIVACY PRACTICES CONTINUED

## DISCLOSURES REQUIRING AUTHORIZATION

**1. Marketing.** Marketing generally includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We will obtain your written authorization to use and disclose your medical information for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law. All other uses and disclosures of your information for marketing purposes require your written authorization. You have the right to revoke such authorization in writing.

## YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information collected and maintained about you:

- 1. Right to Inspect and Copy.** The right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to us.
- 2. Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us or The Joint Corp. To request an amendment, your request must be made in writing and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by us;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- 3. Right to an Accounting of Disclosures.** To request an “accounting of disclosures.” This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations. To request this list you must submit your request in writing to us. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free.
- 4. Right to Request Restrictions.** To request a restriction or limitation on the medical information we use or disclose about you for treatment OR payment. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request, but should any of us agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing and include (1) what information you want to limit; (2) whether you want to limit our use and/or disclosure; and (3) to whom you want the limits to apply.
- 5. Right to Revoke an Authorization.** There are certain types of uses or disclosures that require your express authorization. For example, we may not sell your information to a third party for marketing purposes without first obtaining your authorization. If you provide authorization for a particular use or disclosure of your medical information, you may revoke such authorization in writing by contacting us. We will honor your revocation except to the extent that we have already taken action in reliance of the specific authorization.
- 6. Right to Receive a Copy of this Document.** You have a right to obtain a paper copy of this document upon request.

## CHANGES TO THIS NOTICE

We reserve the right to change our practices and to make the new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting us.

I understand and agree to the patient privacy notice that was presented to me. I also acknowledge that a copy will be made available if I request one.

\_\_\_\_\_  
(Patient Printed Name)

\_\_\_\_\_  
(Patient or Legal Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness / Employee Signature)

\_\_\_\_\_  
(Date)



## PATIENT ACTIVITY ASSESSMENT FORM

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_

The purpose of this form is to assist the doctor in better understanding your daily activities, your ability to perform them, and how they relate to the function of your body. Your answers will provide important information in establishing a customized plan of care designed to place you on the path toward attaining and maintaining your health care goals.

### STANDING OR SITTING

Do you primarily stand or sit at work: Stand / Sit

Approximately how many hours per week:

0-20 hours / 20-40 hours / 40+ hours

Are those hours primarily spent:

On the phone:

Cell / Desktop Phone / Headset / No headset

Typing at a keyboard:

Laptop / Desktop computer

Other: \_\_\_\_\_

What is your most common posture:

Sitting upright / Slouched / Crossed legs / Stand

Does your work require you to:

Bend / Twist / Lift / Carry / N/A

What type of shoes do you wear on a regular basis:

Dress / Heels / Running / Boots / Athletic / Sandals

Other: \_\_\_\_\_

Do you wear orthotics: Yes / No

### SLEEPING

What type of bed do you sleep in:

Memory foam / Adjustable firmness / Inner spring

Other: \_\_\_\_\_

What position do you sleep in: Back / Stomach / Side / All

Do you regularly wake up with any back stiffness: Yes / No

How many hours of sleep do you get per night:

8 hrs or less / More than 8 hrs

Do you regularly wake up with any neck stiffness: Yes / No

### BODY STRESSORS

Do your daily activities require you to lift and/or carry objects: Yes / No

If yes, how often: Occasionally / Frequently / Constant

If yes, approximately, how heavy:

10 lbs or less / 10-30 lbs / More than 30 lbs.

Do you participate in sports: Yes / No

If yes, please indicate all that apply:

Football / Tennis / Dancing / Body building / Racquetball

Soccer / Yoga / Basketball / Walking / Hiking / Volleyball

Cycling or biking / Golf / Other: \_\_\_\_\_

Do you exercise: Yes / No

If yes, approximately how many days per week:

0-1 day(s) / 1-3 days / 3+ days

Type(s) of exercise:

Weight training: Free weights / Machines / Other: \_\_\_\_\_

Do you have children **at home**? Yes / No

If yes, how many? \_\_\_\_\_

Cardio training: Elliptical / Treadmill or Running / Other: \_\_\_\_\_

Do any of your children require you to carry them? Yes / No

### CHIROPRACTIC ACTIVITY ASSESSMENT

Did You Know: the absence of pain is not an indication of health? Yes / No

Did You Know: decreased joint motion can also affect your ability to enjoy a healthy and active lifestyle? Yes / No

Did You Know: pain has a cause and many times that cause begins in the spine? Yes / No

Did You Know: the health benefits of routine chiropractic care may include any of the following: Yes / No

Did You Know: over-the-counter pain medications and / or prescriptions may only mask the pain? Yes / No

- 1) Improved nerve communication
- 2) Improved joint motion
- 3) Improved joint coordination
- 4) Improved physical function
- 5) Improved physical performance
- 6) Improved posture
- 7) Increased daily activity
- 8) Provide pain and stress relief

Did You Know: your daily activities can cause joint pain and dysfunctions in the spine and extremities? Yes / No

Did You Know: these joint dysfunctions can cause decreased joint motion and function in the body? Yes / No