PROACTIVE
CHIROPRACTIC AND PHYSICAL THERAPY

Re-evaluation Form - (Rev.01212022)

Please take a moment to fill out our online re-evaluation form before your visit. All information is kept completely confidential.

If you are unable to complete the form online before your appointment, please arrive 15-20 minutes before your scheduled appointment time, and allow additional time for parking and sanitizing.

COVID-19 REQUIREMENTS If you feel ill or have recently traveled, we ask that you reschedule your visit after 14 days. Masks are required at all times while in the office. We ask that you wash your hands after you enter the building. A sink and antibacterial soap are available as you enter the office hallway. To reduce contact we ask that you make payments and appointments through the patient portal.

Important Parking Information: Please note that our suite cannot be reached through the front of the building. Drive around the left side of the building and enter in the back at Suite 212. We are marked by a large black ramp and blue mailbox. Our reserved patient parking spots are next to the blue mailbox directly in front of our entrance.

For your appointment: Bring your ID, health insurance card, and referral or authorization, if applicable.

Insurance: If you are using health insurance, please provide all of the information listed in the insurance section. If you were involved in an accident (auto,workers comp,etc), please provide your claim information. If your health insurance requires a referral, or if you are a physical therapy patient with Medicare coverage, please bring a referral from a medical doctor.

Section 1

Chief Complaint

What is the primary reason for your visit today? *Required*

Do you have any secondary problems? If yes, please describe

When did your primary complaint begin? *Required*

The onset of the issue was: ***Required***

- ☐ Sudden
- ☐ Gradual

Since the onset, has the problem has gotten: ***Required***

☐ Better ☐ Worse ☐ Stayed the same

Have you ever had this problem before? ***Required***

☐ *Yes* ☐ *No*

What caused your problem? ***Required***

Please rate the severity of your pain. *Please circle one.*

0 1 2 3 4 5 6 7 8 9 10

Have you been treated for this problem in the past? ***Required***

☐ *Yes* ☐ *No*

Has treatment helped this problem in the past? ***Required***

☐ *Yes* ☐ *No*

Does this problem negatively impact any of the following activities? ***Select all that apply. Required***

☐ Sitting ☐ Sleeping ☐ Playing sports

☐ Driving ☐ Bending ☐ Walking

☐ Working ☐ Lifting ☐ Running

Does this problem negatively impact your bowel or bladder functions? ***Required***

☐ *Yes* ☐ *No*

What goals do you hope to achieve with treatment here? ***Required***

Is there anything else you would like to tell the doctor?

Has Your Insurance Changed? *Required.*

☐ *Yes* ☐ *No*

***If yes, please fill out information below*

☐ **Not using insurance**	
Patient's Name	
Patient's Date of Birth	
Name of Insurance Plan	
Member ID Number	
Group Number (if on card)	
Secondary Insurance Name	
Secondary Member ID	
Secondary Policy Holder's Name	
Secondary Policy Holder's Date of Birth	
Relationship to Policy Holder	☐**Self** ☐**Spouse** ☐**Child** ☐**Other** ☐**Not using insurance**

**If Self is not selected, please fill out information below*

Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's Address	

Section 2

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- ☐ I would like email notifications of new, canceled, and rescheduled appointments
- ☐ Email 24 hours before appointment
- ☐ Text Message (SMS) 1 hour before appointment
- ☐ Text Message (SMS) 24 hours before appointment
- ☐ Text Message (SMS) 36 hours before appointment

News and Special Promotions

☐ Yes, I would like to receive news and special promotions by email. Including information about our hours of operation, staff changes, new services, office events, and special discounts.

—---- Consents —----

Accuracy of Information

☐ *I certify that the above medical information is correct to the best of my knowledge.* *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ *I agree* *Required*

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

☐ *I am aware of the Cancellation Policy.* *Required*

Insurance and Payment Policy

Proactive will do their best to work with your insurance company. We will try to look up your benefits before your appointment and let you know what your out of pocket expenses will be for treatment here if the forms are received in adequate time before your appointment. Please also look up your benefits so that we are on the same page. Proactive will securely hold your credit card information to help with payment. For chiropractic services, you will never be charged more than $75 for a follow up visit and $125 for an initial or re-evaluation. For physical therapy services, you will never be charged more than $100 for a follow up visit and $150 for an initial or re-evaluation. For acupuncture, you will never pay more than $120 for follow up visits and $200 for an initial exam. Proactive's no-show fee is a standard $50.

To check your insurance benefits, we utilize the provider portal to see the information online and/or contact the provider service number for the information via a live representative. Please note that the benefit information given to us is not a guarantee of benefits and insurance may or may not cover everything. If for any reason your insurance does not cover your visit, you will be responsible to pay the out of pocket cost of services.

☐ *I understand the Insurance and Payment Policy* *Required*

Signature

_____ Date: _____

Please print First and Last name