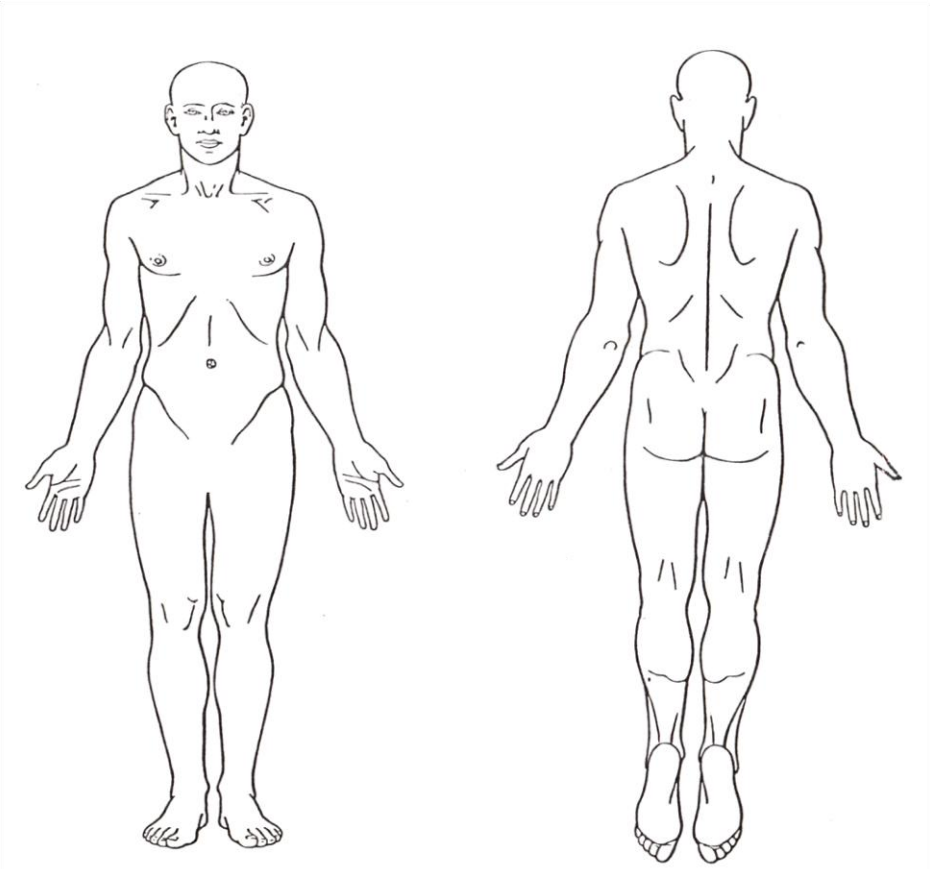
Mark an **X** on the body part(s) where you have **PAIN** NAME: _____

Mark an **O** on the body part(s) where you have **NUMBNESS** DATE: _____



PLEASE CIRCLE THE NUMBERS TO INDICATE YOUR TYPICAL PAIN LEVEL

NECK

0 1 2 3 4 5 6 7 8 9 10
No pain — Moderate pain — Worst possible pain

BACK

0 1 2 3 4 5 6 7 8 9 10
No pain — Moderate pain — Worst possible pain

RIGHT ARM

0 1 2 3 4 5 6 7 8 9 10
No pain — Moderate pain — Worst possible pain

RIGHT LEG

0 1 2 3 4 5 6 7 8 9 10
No pain — Moderate pain — Worst possible pain

LEFT ARM

0 1 2 3 4 5 6 7 8 9 10
No pain — Moderate pain — Worst possible

LEFT LEG

0 1 2 3 4 5 6 7 8 9 10
No pain — Moderate pain — Worst possible

ACTIVE HEALTH

CHIROPRACTIC

Patient Registration Form (PLEASE PRINT)

NAME: _____DOB:_____ SS#: _____
First Middle Initial Last

ADDRESS: _____ CITY/STATE/ZIP: _____

MARITAL STATUS: Single Married Divorced Widowed Separated Minor Partner for ____yrs

SEX: MALE FEMALE EMAIL ADDRESS:_____

HOME #: _____CELL#: _____PREFERRED: CALL or TEXT

PRIMARY CARE DOCTOR: _____ PHONE:_____

EMPLOYER:_____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US: _____

INSURANCE INFORMATION

NAME OF INSURED:_____ DOB: _____ SS#:_____

RELATIONSHIP TO PATIENT: _____ DATE EMPLOYED:_____

NAME OF EMPLOYER:_____ PHONE:_____

INSURANCE CO:_____ PHONE: _____

GROUP #:_____ ID#: _____ EMPLOYER #:_____

DO YOU HAVE ADDITIONAL INSURANCE: YES / NO (If yes, Please complete the following)

NAME OF INSURED:_____ DOB: _____ SS#:_____

RELATIONSHIP TO PATIENT: _____ DATE EMPLOYED:_____

NAME OF EMPLOYER:_____ PHONE:_____

INSURANCE CO:_____ PHONE: _____

GROUP #:_____ ID#: _____ EMPLOYER #:_____

HEALTH HISTORY

CIRCLE ONLY THOSE CONDITIONS WHICH APPLY TO YOU CURRENTLY OR IN THE PAST:

Anxiety	Bulimia	Hypertension	Multiple Sclerosis	Rheumatoid Arthritis
Asthma	Cancer	Heart Disease	Osteoarthritis	Stroke
AIDS/HIV	Cataracts	Hepatitis	Osteoporosis	Thyroid
Alcoholism	Drug Abuse	Hernia	Pacemaker	Tonsillitis
Allergy Shots	Depression	Herniated Disc	Parkinson's Disease	Tuberculosis
Anemia	Diabetes	Herpes	Pinched Nerve	Tumors/Growth
Anorexia	Emphysema	High Cholesterol	Pneumonia	Ulcers
Appendicitis	Epilepsy	Kidney Disease	Prostate Problem	Other_____
Bleeding Disorder	Fractures	Liver Disease	Prosthesis	_____
Bronchitis	Glaucoma	Migraines	Psychiatric Care	_____

FAMILY HISTORY OF DISEASE (List Relationship and condition):_____

_____

(WOMEN) ARE YOU PREGNANT: YES NO NURSING: YES NO

TAKING BIRTH CONTROL PILLS: YES NO MISCARRIAGES: YES NO

ALLERGIES: _____

MEDICATIONS/VITAMINS/NURTITIONAL SUPPLIMENTS:_____

_____

SURGERIES/SPECIAL TESTS & DATE THEY OCCURRED: _____

_____

DAILY HABITS

DO YOU SMOKE: YES NO HOW MUCH PER DAY:_____

DO YOU DRINK ALCOHOL: YES NO HOW MUCH PER WEEK: _____

DO YOU DRINK CAFFEINE: YES NO HOW MUCH PER DAY:_____

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE: YES NO

DO YOU EXCERISE: YES NO WHAT KIND & HOW OFTEN:_____

_____

IF EMPLOYED, HOW PHYSICALLY DEMANDING IS YOUR JOB (circle all that apply):

SEDENTARY LIGHT MODERATE HEAVY

WHAT DO YOUR DAILY WORK HABITS INCLUDE (ex: sitting, standing, computer work, desk job):

_____

_____

DOES YOUR CURRENT INJURY PREVENT YOU FROM WORKING: YES NO

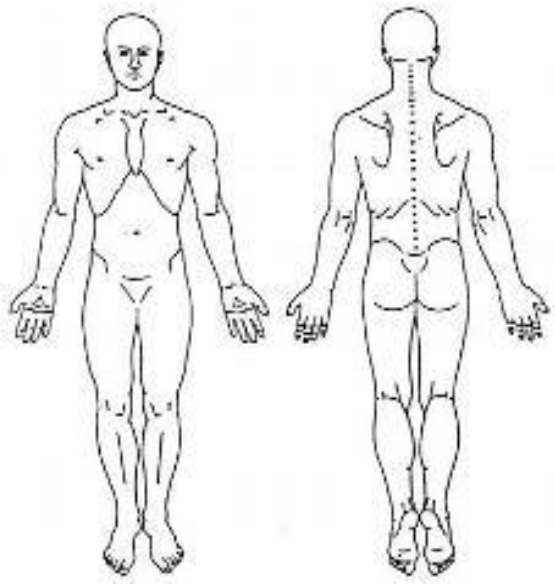
HAS YOUR EMPLOYER MODIFIED YOUR JOB DUTIES DUE TO YOUR INJURY: YES NO

SYMPTOMS

REASON FOR THIS VISIT TODAY:_____

IS YOUR INJURY DUE TO: AUTO ACCIDENT WORK INJURY OTHER

WHERE SPECIFICALLY IS YOUR PROBLEM LOCATED: _____



WHEN DID YOU FIRST NOTICE SYMPTOMS:_____

IS CONDITION GETTING PROGRESSIVELY WORSE: YES NO

TYPE OF PAIN (circle all that apply):

Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other:_____

RATE PAIN (0=No Pain 10=Need to go to ER): 0 1 2 3 4 5 6 7 8 9 10

IS THE PAIN CONSTANT OR DOES IT COME AND GO:_____

WHICH ACTIVIES ARE DIFFICULT TO PERFORM (circle all that apply):

Sitting Standing Walking Bending Lying Down

Reaching Squatting Kneeling Pushing/Pulling Lifting

During Activity After Activity Other:_____

HAVE YOU BEEN TREATED FOR THIS CONDITION (ex: meds, surgery, injections, etc): YES NO

IF YES, PLEASE DESCRIBE:_____

_____

WHAT TESTS HAVE BEEN DONE FOR THIS CONDITION (ex: MRI, XRAY, etc.):

_____

NAME AND PHONE NUMBER OF DOCTOR(S) WHO TREATED/REFERRED YOU FOR THIS CONDITION:_____

_____

_____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, all of the above information is complete and correct. I understand that it is my responsibility to inform my doctor or technician if I, or my minor child, ever have a change in health. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Active Health may use my health care information and may disclose such information to my insurance company or companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment is completed or one year from the date signed below.

_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN TODAY'S DATE

_____

PRINT NAME OF PATIENT OR PARENT/GUARDIAN RELATION TO PATIENT

Office Policies and Procedures Agreement

Active Health
13838 S. 46th Place #300 • Phoenix, AZ 85044

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please free to call us at any time for a copy of our privacy notices.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your Chiropractor, Physical Therapist, and/or staff members may need to use your name, address, phone number, and your clinical records number to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left of your answering machine. By signing this form, you are giving us authorization to contact your with these reminders and information.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions of the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health insurance information if they decide to contest any of your claims.

Initial:_____

FINANCIAL ARRANGEMENTS AND POLICIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports/forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. ***However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if not covered by my insurance. I also understand that if I suspend or terminate my care and treatment, I am still personally responsible for any fees for professional services rendered to me which are not covered by my insurance.***

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for products purchased and services provided by our office. Our office is a participating provider with numerous insurance companies. For your convenience, our office will make an effort to verify your insurance benefits***. However, ultimately it is the patient's responsibility to determine benefit and authorization information before services are rendered.*** Please note that verification of benefits is not a guarantee of benefits. Your insurance company makes the final determination of insurance benefits when they consider the claim. It is understood that despite out best efforts to provide you with a financial estimate of the cost of care, times arise where insurance companies do not reimburse what was originally quoted. If a referral is required but not provided at the time of your visit, full payment is expected at the time of service. Your signature below will give power of attorney to endorse checks made to Active Health, LLC to be credited to your account.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatment. Payment is due within 30 days of services rendered. Bills that are delinquent more than 60 days will be transferred to an outside collection agency unless prior arrangements have been made. Patients will be responsible for collections and attorney fees for all such disputes. If there are legitimate problems, please discuss them prior to the 60 days so we may find a workable solution.

CONSENT FOR RECORDS RELEASE AUTHORIZATION

I hereby grant permission for Active Health, LLC to release any information pertaining to diagnosis and treatment of myself and care in this and other offices to my primary care physician, or to any other physician or therapist who I am currently or previously under care with. I realize the necessity of such purposes and understand that the highest ethical standards will be maintained in maintaining patient confidentiality.

INFORMED CONSENT TO CHIROPRACTIC/WELLNESS/MASSAGE THERAPY CARE

I request and consent to all Chiropractic, Wellness and Massage Therapy procedures and care permitted by Arizona State Law, including medical records review, various methods of Chiropractic, Wellness Therapies, Massage Therapy, necessary Diagnostic X-rays on myself (or on the patient named below, for whom I am regally responsible) by any of the treating doctors, Massage Therapists, and/or any licensed professional deemed appropriate by the office. I understand that results of treatment are not guaranteed. I further understand and am informed that, as in practice of medicine, in the practice of Chiropractic there are risks associated with treatment, although rare, including but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening of symptoms. This consent form covers the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

Initial:_____

I have read your Office Policies and Procedures Agreements and agree to its terms. I am also acknowledging that I have received a copy of this notice. In accordance to all stated, I hereby understand and agree to all of the policies, procedures, and agreements listed.

PRINT Patients Name: _____ DATE: _____

SIGNATURE of Patient:_____

SIGNATURE of Parent or Guardian:_____

WITNESS:_____ DATE: _____