Active Health

Chiropractic & Physical Therapy

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:_____

PHONE (HOME): _____(CELL): _____(WORK):_____

PREFERRED METHOD OF CONTACT: Home Phone Cell Phone Work Phone

PREFERRED METHOD OF APPOINTMENT REMINDERS: Email Message Text Message

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: NO YES (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 COFFEE: YES NO HOW MUCH PER DAY:_____

DO YOU HAVE A HISTORY OF SUBATANCE 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

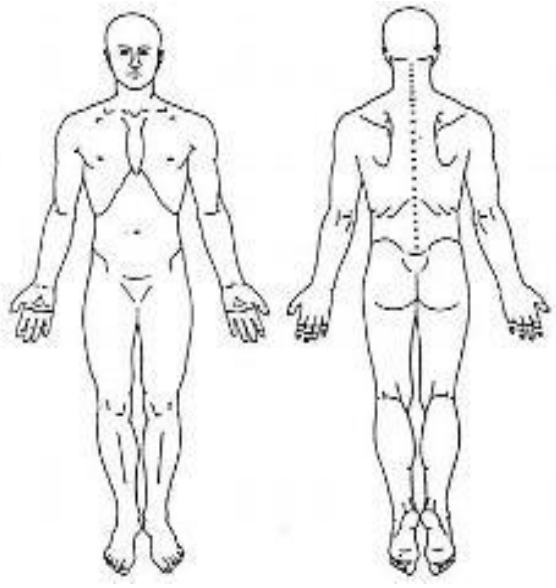
HAS YOUR EMPLOYER MODIFIED YOUR JOB DUTIES DUE TO YOUR INJURY: YES NO

SYMPTOMS

REASON FOR THIS VISIT TODAY:_____

IS YOUR INJURY DUE TO: AUTO ACCIDENT WORK INJURY PERSONAL INJURY

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 physical therapist 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(ies) 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