Welcome to: ACTIVE HEALTH CLINIC

one About you

Today's date: ____/____/_____ File #: _____

Name: _____ What do you prefer to be called? : _____

Male ___ Female ___ Birth Date: ____ /____ / _____ Age: _____ SSN: _____- _____ - _____

Mailing address:

_____

Street City State Zip Code

Home phone #: _____ Cell Phone #: _____

Please tell us who referred you: _____

Who is your employer?: _____

Employer's address:

_____

Street City State Zip Code

Occupation: _____ Work Phone #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's name: _____

Email address: _____

Would you like to receive our e-newsletter? ☐ Yes ☐ No

The reason for your visit two

Please explain the primary reason for visiting our office: (Please explain what happened)

_____

_____

Was this the result of **(circle one)**: auto accident, sports, work injury, trauma or chronic problem?
Please describe your pain (if any) and its location:

_____

_____

When did this begin? (date) ____ /____ /_____ Is the problem getting worse? ☐ Yes ☐ No
Would you describe the problem as **(circle one)** getting better, getting worse, constant, comes and goes?
Is the problem interfering with your work, sleep, daily routine? If so, please describe: _____

_____

Have you ever had this condition before? ☐ Yes ☐ No If so, please describe: _____

_____

Have you sought any other treatment before this? ☐ Yes ☐ No If so, please describe: _____

_____

Have you ever been to a chiropractor before? ☐ Yes ☐ No If so, whom? Name: _____
Where? _____ What did you enjoy most about their care? _____

In event of emergency

three

Who should we contact? _____

Relation: _____

Home #: _____ Work #:_____

Who is your medical doctor? : _____ Phone #: _____

Health history

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxants ☐ Stimulants ☐ Blood thinners

☐ Tranquilizers ☐ Insulin ☐ Other(s): _____

four

Have you had any of the following condition(s)?

☐ Heart Attack/ Stroke	☐ Heart Surgery	☐ Heart Murmur
☐ Congenital Heart Defect	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Alcohol/ Drug Abuse	☐ Venereal Disease	☐ Hepatitis
☐ HIV+ / AIDS	☐ Shingles	☐ Cancer
☐ Arthritis	☐ Emphysema/ Glaucoma	☐ Anemia
☐ Alcohol/ Drug Abuse	☐ Artificial Valves	☐ Indigestion
☐ Frequent Neck Pain	☐ Venereal Disease	☐ Rheumatic Fever
☐ Severe/Frequent Headaches	☐ Asthma	☐ Ulcers/Colitis
☐ Fainting/Seizures/Epilepsy	☐ Kidney Problems	☐ Psychiatric Problems
☐ Diabetes/Tuberculosis	☐ Sinus Problems	☐ Chemotherapy
☐ Lower Back Problems	☐ Difficulty Breathing	
☐ Frequent Mid-Back Pain	☐ Artificial Bones/Joints	

Please list any other serious medical condition you have or ever had:

_____

Please list anything you may be allergic to:

_____

Please list any surgeries you may have had:

_____

Please list any past serious accidents with date(s):

_____

Family Health History (Diabetes, High Blood Pressure, etc.):

_____

Do you smoke? ☐ No ☐ Yes/How much? _____ For how long? _____ Are you wearing: Heel lifts Sole lifts

How old is your mattress? _____ Is it comfortable? _____

For women: Are you taking birth control? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No ☐ Not sure

Are you nursing? ☐ Yes ☐ No

Account Info

five

Person ultimately responsible for this account:

Name of insured: _____ Relationship to patient: _____

Billing address: _____

Work Phone #: _____ Payment method: Cash Check CC #: _____ Exp: _____

Insurance company: _____ Group #: _____ ID#: _____ Phone #: _____

Insurance company address: _____

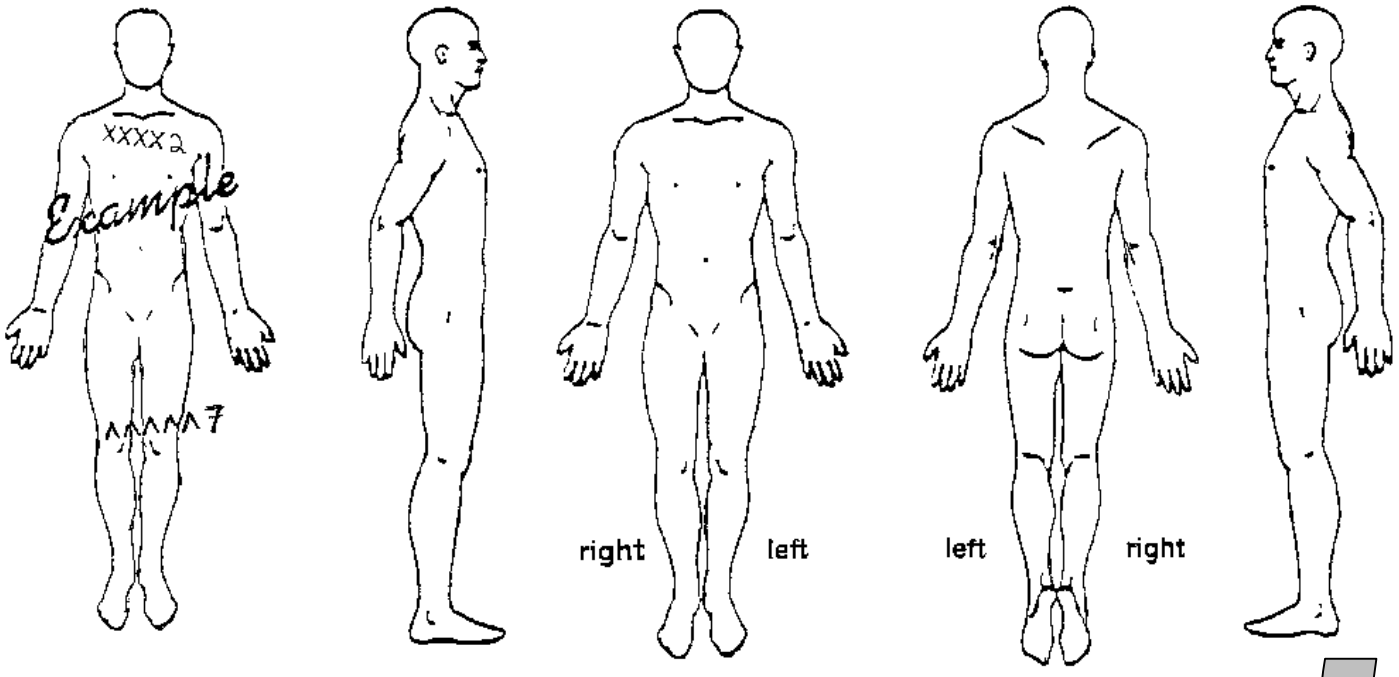
____ **(initial)** I authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Show us where it hurts

six 6

Please show us where you are experiencing symptoms…
Indicate your degree of pain using a scale of **1** (minor discomfort) to **10** (extreme pain):

Numbness:	Pins & Needles:	Burning:	Aching:	Stabbing:
_ _ _ _ _	0000000	^^^^^^^	XXXXXXX	////////



seven 7

* We invite you to discuss with us any questions regarding your care and our services. The best health services are based on a friendly, mutual understanding between provider and patient.

* Our policy requires payment in full for all services at the time of visit, unless other arrangements have been made with the doctor. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. If my account is not paid within 90 days of the date of service, whether the account has been charged to insurance or account and no financial arrangements are made, I will be responsible for any expenses incurred while collecting on my account. I also understand that if I terminate my care at *Active Health Clinic*, any fees for professional services will be immediately due and payable, unless prior arrangements have been made. I hereby authorize the doctors at *Active Health Clinic* and whomever they designate as their assistants to administer treatment as they so deem necessary. I also authorize the provider and / or managed care organization to release my information required to process insurance claims.

* I understand the above information and guarantee this form was completed to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my personal information and medical status.

Signature: _____ Date: _____

Thank you for choosing Active Health Clinic for your chiropractic care!