

Chiropractic Registration & Health History

Legal Name: _____ Date: _____ Sex: ☐ M ☐ F

Preferred name (if applicable): _____ DOB: _____ Age: _____

Address: _____ Apt/Unit (if applicable): _____

City: _____ State: _____ Zip Code: _____

Contact number: _____ Email: _____

Would you like to receive **Text** or **Email** appointment reminders? (Circle one) Yes No

To receive **text** reminders, we need to know your cell service provider: _____

Emergency Contact Name: _____ Phone: _____

Who can we thank for referring you to us? _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Partnered for ____ years ☐ Minor

Occupation: _____

Employer/School: _____

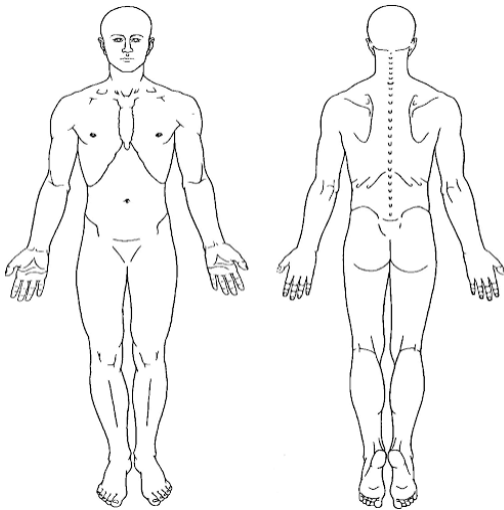
Address: _____

City: _____ Zip: _____

Medications

Allergies

Please mark the area of your body where you feel abnormal sensations and/or pain:



Injury Information

Is your pain today due to an accident?

☐ Yes ☐ No

If yes, what kind? ☐ Work ☐ Vehicle ☐ At Home

☐ Sports Related ☐ Other: _____

Have you reported the accident? If yes, with whom?

☐ Auto insurance ☐ Employer ☐ Work Comp

☐ Not Reported ☐ Other: _____

Attorney Info (if applicable): _____

Reason for visit: _____

When did your symptoms appear? _____ How? _____

Is the condition getting progressively worse? ☐ Yes ☐ No ☐ Not sure

On a scale of 1-10, 10 being the worst, please answer the following questions:

What is your level of pain **right now**? _____ What is your **normal** level of pain? _____

What is your level of pain at its **best**? _____ What is your level of pain at its **worst**? _____

Type of pain: ☐ Sharp ☐ Throbbing ☐ Numbness/Tingling ☐ Aching ☐ Burning ☐ Stiffness

How often do you have this pain? ☐ Constantly ☐ Comes and goes ☐ Other: _____

Does your pain interrupt any activities? ☐ Work ☐ Daily routine ☐ Recreation ☐ Sleeping ☐ Standing

☐ Sitting ☐ Walking ☐ Bending over ☐ Laying down ☐ Other: _____

Health History

Have you already received treatment for your condition? ☐ Medication/Injections ☐ Physical Therapy
☐ Chiropractic Services ☐ Surgery ☐ None ☐ Other: _____
Date of last: Physical _____ Spinal Imaging (MRI, Xray) _____ Spinal Exam _____
Exercise: ☐ None ☐ Moderate ☐ Daily **Work Activity:** ☐ Sitting ☐ Standing ☐ Light lifting ☐ Heavy lifting
Are you currently pregnant? If yes, what is your due date? _____

Please check the box if you have/had any of the following:

- | | | |
|--|---|---|
| ☐ Alcoholism | ☐ Diabetes | ☐ Osteoporosis |
| ☐ Allergy Shots | ☐ Epilepsy | ☐ Pacemaker |
| ☐ Anemia | ☐ Fractures | ☐ Parkinson's Disease |
| ☐ Anorexia | ☐ Gout | ☐ Pinched Nerve |
| ☐ Appendicitis | ☐ Heart Disease | ☐ Prosthesis |
| ☐ Arthritis | ☐ Hernia | ☐ Rheumatoid Arthritis |
| ☐ Asthma | ☐ Herniated Disc | ☐ Stroke |
| ☐ Bleeding Disorder | ☐ Joint Replacement | ☐ Thyroid issues |
| ☐ Breast Lump | ☐ Liver Disease | ☐ Other: _____ |
| ☐ Cancer | ☐ Migraines | _____ |
| ☐ Chicken Pox | ☐ Multiple Sclerosis | _____ |

Health Symptoms Checklist

Please check any symptoms that you have experienced in the **last 3 months**:

- | | | |
|---|--|---|
| ☐ Fever/Chills | ☐ Chest pain or tightness | ☐ Headaches/Migraines |
| ☐ Unexpected weight loss of 10lbs or more | ☐ Shortness of breath | ☐ Unconsciousness |
| ☐ Difficulty sleeping: If yes, How long does it take you to fall asleep? _____ | ☐ Pain in the abdomen/stomach | ☐ Difficulty speaking |
| ☐ How many times do you wake up at night? _____ | ☐ Nausea or vomiting | ☐ Poor motor skills |
| ☐ Sleep apnea | ☐ Irregular/Accidental bowel movements | ☐ Difficulty walking |
| ☐ Double vision, or Loss of vision | ☐ Constipation | ☐ Loss of Balance |
| ☐ Swelling in feet or ankles | ☐ Diarrhea | ☐ Numbness/Tingling in arms or hands |
| | ☐ Urination issues | ☐ Weakness in arms or hands |
| | ☐ Accidental urination | ☐ Weakness in thighs, legs, or feet |
| | ☐ Leg cramps while walking, or at night | ☐ One-sided weakness: L R |

Did we miss anything you'd like us to know about your condition? _____

Have you had any falls recently? ☐ No ☐ Yes, how did it happen and when? _____

Head injuries? ☐ No ☐ Yes, when? _____

Broken bones or dislocations? ☐ No ☐ Yes, please explain _____

For women only: Are you pregnant? ☐ No ☐ Yes, what is your due date? _____

Patient Rights & Privacy Practices

At Active Chiropractic & Rehabilitation, we are committed to protecting your health information and respecting your rights as a patient. This document outlines your rights regarding your medical information and explains how we may use and disclose your protected health information (PHI) in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). You have the right to:

- ✓ Access and obtain a copy of your health records.
- ✓ Request corrections to your medical information if you believe it is inaccurate or incomplete.
- ✓ Request restrictions on certain uses or disclosures of your health information.
- ✓ Request confidential communications (such as contacting you at a specific phone number)
- ✓ Receive a record of certain disclosures of your health information.
- ✓ Obtain a copy of this notice upon request.

Use and Disclosure of Protected Health Information

While your health information is kept confidential, there are certain situations in which we are permitted or required to use and disclose your protected health information without your specific authorization. These situations include, but are not limited to:

Treatment Purposes: We may use and share your health information as necessary to provide, coordinate, or manage your chiropractic care. This includes communication with other healthcare providers involved in your treatment.

Referrals: Over the course of your care, we may refer you to other healthcare providers, specialists, or facilities. In doing so, we may share relevant health information to ensure continuity and quality of care.

Payment and Billing: We may use and disclose your information to obtain payment for services rendered, including submitting claims to insurance companies, verifying coverage, and processing billing activities.

Healthcare Operations: We may use your information for internal operations such as quality assessment, staff training, and administrative purposes.

Legal and Regulatory Requirements: We may disclose your health information when required by federal, state, or local law, including public health reporting, compliance with court orders, or other legal obligations. However, we are required by law to:

- ✓ Maintain the privacy and security of your protected health information.
- ✓ Provide you with this notice of our legal duties and privacy practices.
- ✓ Follow the terms of this notice currently in effect.

Please note that our office maintains a scheduling policy to ensure availability for all patients. In the event of a missed appointment without prior notice (“no call, no show”), a fee of \$30.00 will be applied to your account for each occurrence.

By signing below, you acknowledge that you have been informed of your rights and our privacy practices regarding your health information. You also acknowledge and agree to our office policies.

Patient Signature _____ Date _____

Parent/Guardian Signature (If necessary) _____