Chiropractic Registration & Health History

Legal Name: _____ Date: _____

DOB: _____ Preferred name (if applicable): _____ Sex: □ M □ F

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: _____

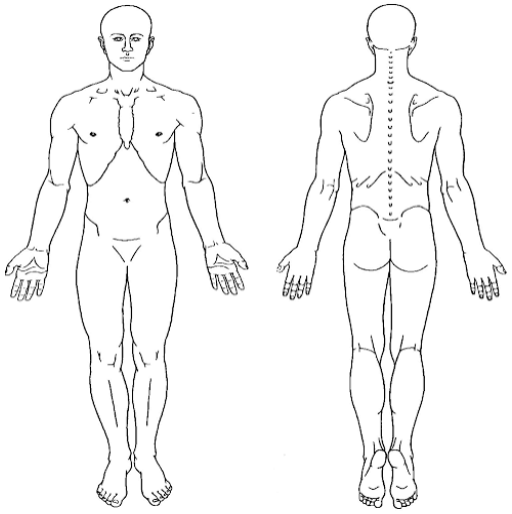
Marital status: □ Single □ Married □ Widowed □ Partnered for ____ years □ Minor

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

Health Symptoms Checklist

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

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