Active Health New Patient Questionnaire

Please Print. **Medical Records#_____**

Name:_____Date_____Social Security#_____

Address:_____City:_____State:_____Zip:_____

E-mail address:_____Phone:_____CellPhone:_____

Male Female Married Single Widowed Divorced Separated

Birthdate_____Occupation:_____Employer:_____

Spouse/parent:_____Occupation:_____Employer:_____

Emergency Contact:_____ Relation:_____ Phone#_____

Whom May We Thank For Referring You to Active Health?_____

Family Medical Doctor:_____ May We Contact? _____

Insurance Information- If Insured Please Provide a Copy Of Insurance Card.

History Of Present Illness:

Main Injury/ Purpose of today's visit:_____

What does this prevent you from doing or enjoying?_____

When was the first time you noticed this problem and how did it originally occur?_____

_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how? _____

Days lost from work:_____ Rate Pain (0 is pain free-10 is unbearable pain) **1 2 3 4 5 6 7 8 9 10**

Pain Due to (circle): Auto Work Other **Is the Pain (circle):** Constant Daily Intermittent Night Only

How Long (circle): All Day Few Hours Minutes

Describe (circle): Sharp Dull Numb Tingling Aching Burning Stabbing Other _____

What Makes Problem Worse(circle): Standing Sitting Lying Bending Lifting Twist

What Makes the Problem Better?_____

Are there any other conditions or symptoms?_____

Have you ever had the same or a similar condition? ___Yes ___ No If yes, when and describe:

_____

Other Chiropractors?_____Positive Experience?_____

Past Medical History- ***please circle all that apply***

Broken or Fractured Bones	Osteoarthritis	Eating Disorder	Herniated Disc
Circulatory Problems	Epilepsy	Alcoholism	Kidney Disease
Rheumatoid Arthritis	Pace Maker	Drug Addiction	Thyroid
Seizures/Convulsions	Strokes	HIV Positive	Stroke
A Congenital Disease	Cancer	Gall Bladder	Diabetes
Excessive Bleeding	Ruptures	Depression	M.S.
High/Low Blood Pressure	Coughing Blood	Ulcers	Fibromyalgia/Chronic Fatigue

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? **Women**, please include information about childbirth (include dates)_____

_____

Previous Surgeries and Dates? _____

List **ALL** medications you are currently taking: _____

_____

Do you have any allergies to any medications? ___Yes ___ No

If yes, describe:_____

Do you have any allergies of any kind? ___ Yes ___ No

If yes, describe:_____

Do you drink alcoholic beverages?___ If so, how much per week?_____

Do you use any tobacco products?_____Do you smoke?____ #of packs a day_____

Do you take vitamin supplements?_____ If so, please list:_____

Do you consume caffeine?____ If so, how much per day:_____

Do you exercise?_____ If yes, what is the frequency and type of exercise?_____

What are your hobbies?_____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting_____ sitting_____ bending_____working at a computer_____

Family History Parents:

Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Mother: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Family Health History- (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis____
Diabetes ____
Stroke _____
Arthritis_____
Other _____

Cancer____
Asthma____
Kidney Disease____
Liver Disease ____

Mental Illness____
Heart Disease ____
Lung Disease____

***Women Only*:** Are you pregnant or is there any possibility you may be pregnant? **(circle)** Yes No

Date of LMP_____

Please check any and all insurance coverage that may be applicable in this case:

__ Major Medical ___ Worker's Compensation ___ Medicaid ___ Medicare ___ Auto Accident

___ Medical Savings Account & Flex Plans ___ Other (Cash, Check, Visa, MasterCard)

Name of Primary Insurance

Company:_____

Name of Secondary Insurance Company (if any):_____

Name & DOB of Insurance Subscriber: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____