ACTIVE HEALTH & RESTORATION

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. First Name: _____ Middle _____Last _____

Nickname: _____Gender: M F Date of Birth: _____/_____/_____ Student: Y N

Marital Status: S ☐ M ☐ D ☐ W ☐ Patient's Employer: _____

Patient's Address: _____City: _____ State: _____ Zip: _____-_____

Home Phone: _____-_____-_____ Cell: _____-_____-_____ Work Phone: _____-_____-_____

Person Financially Responsible Self: ☐ Other: ☐ Patient's Email: _____

Body Part to Be Treated: _____Condition Related to: Work ☐ Auto Accident ☐ Other Accident ☐

Referring Dr. _____Employer's Address: _____ City: _____

State: _____ Zip: _____-_____ Job Title: _____ Date of Onset/Injury: ____/____/_____

Date of Surgery: _____/_____/_____ SS#: _____-_____-_____ Spouse: _____

Person Financially Responsible/Relationship: _____/_____

Attorney/City/Phone: _____/_____/_____-_____-_____

Emergency Contact/Relationship: _____/_____

Emergency Contact's Phone: _____-_____-_____ Referred By: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone: _____-_____-_____

Policy Holder's First Name: _____ MI: _____ Last: _____

Policy Holder's Date of Birth: ____/____/____ SS#: _____-_____-_____ Gender: M ☐ F ☐

Relationship to Patient: _____ Policy Holder's Employer: _____

Policy Holder's Address: _____ City: _____ State: _____

Zip: _____-_____ Group #: _____ Policy #/ID#/Claim #: _____

Adjuster/NCM Name: _____Adjuster/NCM Phone: _____-_____-_____

Secondary Insurance Company: _____ Phone: _____-_____-_____

Policy Holder's First Name: _____ MI: _____ Last: _____

Policy Holder's Date of Birth: ____/____/____ SS#: _____-_____-_____ Gender: M ☐ F ☐

Relationship to Patient: _____ Policy Holder's Employer: _____

Policy Holder's Address: _____ City: _____ State: _____

Zip: _____-_____ Group #: _____ Policy #/ID#/Claim #: _____

Adjuster/NCM Name: _____Adjuster/NCM Phone: _____-_____-_____

MEDICAL HISTORY

Chief Complaint: _____

Current Symptoms: Pain Numbness Stiffness Weakness New Acute Chronic

Medications Currently Taken: _____

Allergic to the Following Medications: _____

List Surgeries: _____

Previous Diagnostic or Rehabilitative Services for This Condition: MRI Xrays Other: _____

_____

Do you have any of the following?

	YES	NO
Asthma, Bronchitis, or Emphysema	____	____
Shortness of Breath/Chest Pain	____	____
Coronary Heart Disease	____	____
Do you have a Pacemaker	____	____
High Blood Pressure	____	____
Heart Attack/Surgery	____	____
Stroke/TIA	____	____
Blood Clot/Embolism	____	____
Epilepsy/Seizures	____	____
Thyroid Trouble/Goiter	____	____
Anemia	____	____
AIDS/HIV	____	____
Hepatitis	____	____
Infectious Disease	____	____
Diabetes	____	____
Cancer or Chemo/Radiation	____	____
Arthritis/Swollen Joints	____	____
Osteoporosis	____	____
Varicose Veins	____	____
Gout	____	____
Sleeping Difficulties	____	____
Emotional/Psychological Problems	____	____
Bowel or Bladder Problems	____	____
Severe Frequent Headaches	____	____
Vision/Hearing Difficulties	____	____
Dizziness or Faintness	____	____
Are you pregnant?	____	____

Smoking Daily ____ Weekly ____

Alcohol Consumption Daily ____ Weekly ____

Pain when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending	____	____	____	____
Care for Infirm Family	____	____	____	____
Carrying Groceries	____	____	____	____
Change Pos (Sit to Stand)	____	____	____	____
Climb Stairs	____	____	____	____
Driving	____	____	____	____
Extended Computer Use	____	____	____	____
Feeding (Self)	____	____	____	____
Household Chores	____	____	____	____
Kneeling	____	____	____	____
Lift Children	____	____	____	____
Lifting	____	____	____	____
Pet Care	____	____	____	____
Reading (Concentration)	____	____	____	____
Self Care-Bathing	____	____	____	____
Self Care-Dressing	____	____	____	____
Self Care-Shaving	____	____	____	____
Sexual Activities	____	____	____	____
Sleep	____	____	____	____
Sitting (Prolonged)	____	____	____	____
Standing (Prolonged)	____	____	____	____
Walking	____	____	____	____
Yard Work	____	____	____	____
Sports	____	____	____	____
Recreational Activities	____	____	____	____

Exercise Daily ____ Weekly ____

Other Medical Conditions: _____

_____

Are you aware of your Diagnosis? YES ____ NO ____ Are you aware of your Prognosis? YES ____ NO ____

I hereby agree and give my consent to medical treatment by Active Health & Restoration and realize that I have the right to refuse any treatment. I authorize release of any medical information to my insurance company representatives, my employer if a worker's comp claim, primary care physician, referring physician, and any third party payers. If not a worker's comp claim, I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Active Health & Restoration regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred. I authorize that messages about my care, appointments, etc., may be communicated to me via voicemail, text message, and/or email.

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: ____/____/___