



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	Pain when performing the following activities?	Mild	Moderate	Severe	Unable
Asthma, Bronchitis, or Emphysema	_____	_____	Bending	_____	_____	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Care for Infirm Family	_____	_____	_____	_____
Coronary Heart Disease	_____	_____	Carrying Groceries	_____	_____	_____	_____
Do you have a Pacemaker	_____	_____	Change Pos (Sit to Stand)	_____	_____	_____	_____
High Blood Pressure	_____	_____	Climb Stairs	_____	_____	_____	_____
Heart Attack/Surgery	_____	_____	Driving	_____	_____	_____	_____
Stroke/TIA	_____	_____	Extended Computer Use	_____	_____	_____	_____
Blood Clot/Embolism	_____	_____	Feeding (Self)	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	Household Chores	_____	_____	_____	_____
Thyroid Trouble/Goiter	_____	_____	Kneeling	_____	_____	_____	_____
Anemia	_____	_____	Lift Children	_____	_____	_____	_____
AIDS/HIV	_____	_____	Lifting	_____	_____	_____	_____
Hepatitis	_____	_____	Pet Care	_____	_____	_____	_____
Infectious Disease	_____	_____	Reading (Concentration)	_____	_____	_____	_____
Diabetes	_____	_____	Self Care-Bathing	_____	_____	_____	_____
Cancer or Chemo/Radiation	_____	_____	Self Care-Dressing	_____	_____	_____	_____
Arthritis/Swollen Joints	_____	_____	Self Care-Shaving	_____	_____	_____	_____
Osteoporosis	_____	_____	Sexual Activities	_____	_____	_____	_____
Varicose Veins	_____	_____	Sleep	_____	_____	_____	_____
Gout	_____	_____	Sitting (Prolonged)	_____	_____	_____	_____
Sleeping Difficulties	_____	_____	Standing (Prolonged)	_____	_____	_____	_____
Emotional/Psychological Problems	_____	_____	Walking	_____	_____	_____	_____
Bowel or Bladder Problems	_____	_____	Yard Work	_____	_____	_____	_____
Severe Frequent Headaches	_____	_____	Sports	_____	_____	_____	_____
Vision/Hearing Difficulties	_____	_____	Recreational Activities	_____	_____	_____	_____
Dizziness or Faintness	_____	_____					
Are you pregnant?	_____	_____					
Smoking	Daily _____	Weekly _____	Exercise		Daily _____	Weekly _____	
Alcohol Consumption	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: ____/____/____