ACTIVE CHIROPRACTIC & REHABILITATION, LLC.

Patient Registration and History

Date:

Patient information

Please circle one: Mr. Mrs. Miss Ms. Dr. Sex: M F Date of Birth: _____

Name: _____ Marital Status: S M W D

Address: _____

_____

Home Phone: _____ Email Address: _____

Cell Phone: _____ _____

We typically send out appontment reminders by text. Please check here [ ] to opt out.

Job

Occupation: _____ Employer: _____

Address: Phone #:

Insurance

Please have card copied at front desk

Insured Name (If different from Patient): _____

Relationship to Pt: Insured D.O.B.:

ICE

Emergency Contact: _____ Cell #: _____

Relationship to Pt: Home #:

MD's

Primary MD: _____ Practice Name: _____

Last Physical Date: _____

Other Doctors:

Injury Information

Major Complaint: _____

Is your complaint due to the following? ___ Employment ___ Automobile Accident ____ Other

If employment has your employer been notified? Y N Date of Incident: _____

If auto, have you filled out the application for medical benefits? Y N

Referral

Whom may we thank for referring you to our office?

____ Doctor ___ Patient ___ Our Website ___ Online search ___ Insurance Company

Name of Source:

Consent

I voluntarily consent to receive medical and healthcare services that may include diagnostic procedures, examination, and treatment.

Financial

I Hereby assign, transfer, and set over to Thomas F. Antonucci, DC and Active Chiropractic and Rehabilitation, LLC, all of my rights, title, and interest to my medical re-imbursement benefits under my insurance policy. I also authorize the release of any medical information needed to determine these benifits. The authorization will remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges wether or not they are covered by insurance.

HIPAA

Under National HIPAA guidelines we may not release ANY information about your healthcare (ie, appointments, condition, diagnosis, studies, treatment plan, etc.) without direct authorization from you (except for payment purposes with your insurance company or by court order).

I Authorize Active Chiropractic and Rehabilitation, LLC to leave messages on my supplied telephone number regarding delivery of products and appointments only (no medical information)

List of family members or persons that the doctor may discuss my healthcare with or is authorized to pick up my records if the case arises.

Name: _____ _____ ____/____/_____

Print Sign Date

ACTIVE CHIROPRACTIC & REHABILITATION, LLC.

Patient History

Name: _____ Date: _____

1 Complaint(s): _____

2 Onset Date: _____

3 Cause:

( ) Trauma: _____ ( ) Woke with it

( ) Slow onset over _____ Days / months ( ) Unknown

( ) Other: _____

4 Since the onset, pain interferes with:

( ) Sitting After _____ (Minutes / Hours)

( ) Standing After _____ (Minutes / Hours)

( ) Walking After _____ (Minutes / Hours)

( ) Activities of Daily living:

( ) Getting dressed ( ) Bathing / Showering ( ) Cleaning the house

( ) Sleep: ( ) Getting to sleep ( ) staying alseep

( ) Recreational activities:

( ) Golf ( ) Basketball ( ) Softball ( ) Running ( ) Cycling ( ) Other: _____

5 History of pain:

( ) Comes and goes for years ( ) Constant for years ( ) Never had this before

6 Problems or changes with the following? Check all that apply or ( ) All Negative

( ) Sense of smell ( ) Blurred vision ( ) Speech ( ) Memory

( ) Sense of taste ( ) Swallowing ( ) Balance

( ) Hearing ( ) Facial weakness ( ) Numbness / pain in the face

7 Goal(s) for Care: ( ) Pain Relief ( ) Correction of Underlying Problem

( ) Learn of Healthier Lifestyle

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8 Accidents / Injuries / Falls: _____

_____

_____

9 Conditions / Illnesses: _____

_____

10 Surgeries: _____

_____

11 Fractures: _____

_____

12 Hospitilizations: _____

13 Recent X-Rays / MRI's: _____

Pregnancies: _____

14 Are you or could you be currently pregnant? Y / N _____

Allergies: _____

15 _____

Medications: _____

16 _____

Supplements: _____

17 _____

18 Water Intake: _____ Ounces / bottles per day _____

19 Smoke: ( ) Yes - _____ packs / day ( ) No - Quit _____ yrs ago ( ) No - Never did