



Welcome to Active Body!

To help us complete our records and submit accurate bills to your insurance company, please assist us by filling out the following questions. If auto-filled information is wrong please correct it. If you have any questions the receptionist will gladly help you.

Patient First Name: _____ Last Name: _____

Middle Initial: _____

Date of Birth: _____

Social Security Number: _____ (needed for insurance patients)

Current Home Address: _____

City: _____ State: _____ Zip Code: _____

Current marital status? (Single, Married or Other): _____

Occupation: _____

Employer: _____

Contact Info: (please give us any acceptable numbers to call you on)

Home phone: _____ Cell phone: _____

Work phone: _____

Appointment Reminders: Our preferred method of reminding patients about appointments is by e-mail but we can call if you prefer. (note: your email is kept private and only used for appointment reminders). Please select which you would prefer:

E-mail address: _____

Please call me for reminders I don't need appointment reminders (opt out)

How did you find us?: Please help us out by describing how you found out about our clinic. If it was a friend, who was it? If you found us on the internet, on which search engine or website did you find us? This information is greatly appreciated!

Health Insurance Patients: We need your current insurance card and a photo identification card. If this insurance is not under your name, please enter the following:

Name of the Insurance Holder: _____ Relation to Patient: _____

Date of Birth of the Insured: _____

Other Payment Methods for Services:

Self Pay - credit card, check or cash accepted; payment due at time of service.

Auto Accident / Worker's Comp - we may accept assignment for these cases.

Identification: A valid PHOTO identification is required of all patients or guardians.

• Please indicate any of the following activities that **AGGRAVATE YOUR PAIN:**

- BENDING REACHING COUGHING SITTING LYING DOWN
 MOVEMENT OF THE AREA LIFTING SNEEZING WALKING
 STANDING OTHER _____
-

• Please indicate any of the following activities that **RELIEVE YOUR PAIN:**

- RESTING SITTING MOVEMENT HELPS STANDING UP LYING DOWN
 IBUPROFEN / MEDICATIONS ICE HEAT WALKING STRETCHING
 OTHER _____
-

• Please indicate any additional symptoms you are currently experiencing:

- | | | | | |
|---|---|--|--|--------------------------------|
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> cold hands | <input type="checkbox"/> upset stomach | <input type="checkbox"/> face flushed | <input type="checkbox"/> fever |
| <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> cold sweats | <input type="checkbox"/> dizziness | <input type="checkbox"/> fainting | |
| <input type="checkbox"/> headaches | <input type="checkbox"/> cold feet | <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> insomnia | <input type="checkbox"/> light bothers eyes | <input type="checkbox"/> loss of balance | |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> loss of taste | <input type="checkbox"/> muscle jerking | <input type="checkbox"/> numbness in fingers | |
| <input type="checkbox"/> numbness in toes | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> stiff neck | |
| <input type="checkbox"/> pins and needles in arms | <input type="checkbox"/> pins and needles in legs | | | |
| <input type="checkbox"/> concentration loss/confusion | <input type="checkbox"/> depression /weeping spells | | | |
| <input type="checkbox"/> head seems too heavy | <input type="checkbox"/> low resistance to colds | | | |

• Do you smoke?

- Current smoker Past smoker Occasional / Social smoker Never

• Do you have any allergies? No Yes (Describe): _____

• Are you currently taking any medications? No Yes (Describe): _____

• Are you currently pregnant or think you may be pregnant? No Yes

FAMILY HISTORY: To the best of your knowledge, please indicate which PAST or PRESENT conditions have been experienced by yourself, your mother, or your father by marking appropriate boxes.

			S = Self			M = Mother			F = Father								
<i>S</i>	<i>M</i>	<i>F</i>	<i>S</i>	<i>M</i>	<i>F</i>	<i>S</i>	<i>M</i>	<i>F</i>	<i>S</i>	<i>M</i>	<i>F</i>	<i>S</i>	<i>M</i>	<i>F</i>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	dislocated joints	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	epilepsy	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	German measles	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	headaches	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	heart trouble	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	reproductive disorders	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	high blood pressure	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	HIV	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	kidney disorder	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	bowel control loss	convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cramps	sinus trouble	diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MS	Stroke	indigestion

SURGICAL HISTORY: Please indicate any major surgeries and approximate date.

1. _____	Date: _____
2. _____	Date: _____
3. _____	Date: _____
4. _____	Date: _____

Do you have any metal objects or surgical devices in your body? No Yes

ACCIDENT HISTORY: Please describe any automobile or other major accidents you have been involved in and their approximate date:

1. _____	Date: _____
2. _____	Date: _____
3. _____	Date: _____
4. _____	Date: _____

Is there any other important information you would like to add?



STATEMENT of AUTHORIZATION / UNDERSTANDING
and ASSIGNMENT of BENEFITS
(Please read carefully before signing)

I, the undersigned, hereby authorize the staff of Active Body to perform such services as deemed necessary by the physician to diagnose and treat my condition(s).

I authorize assignment of my insurance rights and benefits directly to this provider in order to pay for my medical bills. I also authorize the release of such information as is needed to process insurance claims by provider or agent.

I understand that I am responsible for the payment of all co-pays and deductibles associated with my insurance plan and in the event of non-payment by my insurance company I understand that I am responsible for all medical bills incurred at Active Body. Active Body will not be held accountable for mis-information regarding my insurance benefits and coverage. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account.

I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Name:

(*If you are the patient's Guardian please print your name: _____)

SIGNATURE of Patient (or Guardian):

X _____