

**ACTIVE SPINAL AND SPORTS CARE, INC.**

**NEW PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
LAST FIRST MI  
 S.S. # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender:  Male  Female Age: \_\_\_\_ Primary Language: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Phone:  Cell  Home  Work Cell (\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_  
 Work (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
 Preference for Appointment Reminders:  Email  Text Name of Cell Carrier: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Work Status:  Employed  Unemployed  Retired  Student  
 Marital Status:  Single  Married  Divorced  Widowed Children:  Yes  No How many? \_\_\_\_\_  
 Spouse (or Parent) Name: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Primary Care Physician Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 How did you hear about our office?  www.activespinal.com  Insurance Referral  Internet: \_\_\_\_\_  
 Referred by one of our patients: Name \_\_\_\_\_  Other: \_\_\_\_\_

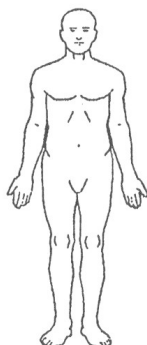
**INSURANCE / PAYMENT INFORMATION DO YOU HAVE HEALTH INSURANCE?  YES  NO If yes, continue:**

Insurance Company Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
DO YOU HAVE MEDICARE "PART B" HEALTH INSURANCE?:  YES  NO Medicare # \_\_\_\_\_  
IS YOUR INJURY WORK RELATED?  YES  NO If yes, continue: Date of injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Have you reported the injury to your employer?  YES  NO  UNDECIDED  
IS YOUR INJURY RELATED TO AN AUTOMOBILE ACCIDENT?  YES  NO If yes, continue:  
 Have you reported an injury claim to your Auto Insurance?  YES  NO Date of accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Your Auto Insurance Company: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Auto Insurance Address: \_\_\_\_\_  
 Adjuster's Name: \_\_\_\_\_ Adjuster's Phone: (\_\_\_\_) \_\_\_\_\_ Ext.: \_\_\_\_\_  
 Is there a Medical Payment provision on your auto policy?  YES  NO  NOT SURE Amount: \$ \_\_\_\_\_

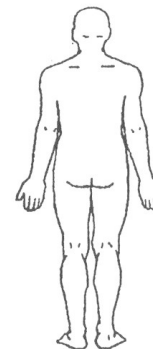
**PATIENT CONDITION**

Chief Complaint: 1. \_\_\_\_\_ How Long? \_\_\_\_\_ Previous episode?  YES  NO  
 2. \_\_\_\_\_ How Long? \_\_\_\_\_ Previous episode?  YES  NO  
 3. \_\_\_\_\_ How Long? \_\_\_\_\_ Previous episode?  YES  NO

*Please mark on the drawings area and type of pain, using the codes indicated.*



**N-Numbness  
 T-Tingling  
 S-Soreness  
 P-Pain  
 A-Ache  
 ST-Stiffness**



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Date you first noticed symptoms: \_\_\_\_\_ Describe how they began: \_\_\_\_\_

How often are your symptoms present?  0%-25% (Occasional)  26%-50%  51%-75%  76%-100% (Constant)

How would you describe the symptoms?  Sharp  Shooting  Stabbing  Weakness  Dull  Burning  Stiffness  
 Throbbing  Numb  Tingling  Cramps  Achy  At Night  Unrelieved by position or rest

How are your symptoms changing?  Getting Better  Getting Worse  Not Changing \_\_\_\_\_

How would you rate your symptoms? (Use a scale of 0 – 10 where: 0 = none; 10 = most extreme) Best: \_\_\_\_\_ Worst: \_\_\_\_\_

Rate interference with your daily activities in the past week (0 = none; 10 = unable to carry on activities) \_\_\_\_\_

What makes your symptoms Worse? \_\_\_\_\_ Better? \_\_\_\_\_

Have you seen any other health care professionals for this condition?  YES  NO If yes, please list:

Name/Specialty/Date: \_\_\_\_\_ Name/Specialty/Date: \_\_\_\_\_

Have you had any tests done for your symptoms?  YES  NO If yes, please check test and give approximate date and area:

X-Rays \_\_\_\_\_  CT Scan \_\_\_\_\_  MRI \_\_\_\_\_  Lab \_\_\_\_\_  Other \_\_\_\_\_

Please indicate findings if known: \_\_\_\_\_

Have you seen any other health care professionals for any other condition?  YES  NO If yes, please list:

Name:/City/Date: \_\_\_\_\_

Have you ever received chiropractic care before?  YES  NO If yes, describe: \_\_\_\_\_

**EXERCISE, WORK, ACTIVITY HABITS**

Exercise:  None  Light  Moderate  Heavy # Days/Week: \_\_\_\_\_  Running (distance): \_\_\_\_\_

Marathon/Triathlon  Cycling  Other Sports: \_\_\_\_\_

Does Your Work Involve:  Extensive Sitting  Extensive Standing  Light Labor  Heavy Labor

Alcohol: Drinks / Week \_\_\_\_\_  Caffeine: Cups / Day \_\_\_\_\_  Smoking: Packs / Day \_\_\_\_\_

High Stress: Reason \_\_\_\_\_

**FAMILY HISTORY:**  Cancer  Diabetes  High Blood Pressure  
 Heart Problems  Rheumatoid Arthritis  Stroke

PATIENT NAME \_\_\_\_\_ DATE: \_\_\_\_\_

**HEALTH HISTORY** Check a box to indicate if you have now, or have a history of any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Stroke Date: _____                 |
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Thyroid Disorder                   |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Fever, recent    | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Ankle Swelling          | <input type="checkbox"/> Fractures        | <input type="checkbox"/> Nausea             | <input type="checkbox"/> Ulcers                             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Venereal Disease                   |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Numbness           | <input type="checkbox"/> Visual Disturbances                |
| <input type="checkbox"/> Bowel/Bladder Problem   | <input type="checkbox"/> Gout             | Area: _____                                 | <input type="checkbox"/> Vomiting                           |
| <input type="checkbox"/> Breathing Problem       | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Weight, Abnormal:                  |
| <input type="checkbox"/> Cancer: Explain _____   | <input type="checkbox"/> Heartburn        | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Gain <input type="checkbox"/> Loss |

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- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Chest Pain         | <input type="checkbox"/> Heart Problem       | <input type="checkbox"/> Pinched Nerve    | <input type="checkbox"/> Currently pregnant?<br># of weeks _____             |
| <input type="checkbox"/> Chronic Cough      | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Pins / Needles   | <input type="checkbox"/> Corticosteroid Use<br>(Cortisone, Prednisone, etc.) |
| <input type="checkbox"/> Cold Limbs         | <input type="checkbox"/> Herniated Disc      | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Taking Birth Control Pills                          |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Polio            | <input type="checkbox"/> Other health problems<br>_____                      |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problem | _____  |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Prosthesis       | _____  |
| <input type="checkbox"/> Digestive Problem  | <input type="checkbox"/> Infections          | <input type="checkbox"/> Psychiatric Care | _____  |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Rheumatic Fever  | _____  |
| <input type="checkbox"/> Eating Disorder    | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Ringing in Ears  | _____  |
| <input type="checkbox"/> Epilepsy/Seizures  | <input type="checkbox"/> Loss of Sleep       | <input type="checkbox"/> Stiffness        | _____  |

**In general would you say your overall health right now is:**

- Excellent     Very Good     Good     Fair     Poor

**INJURIES / SURGERIES / ACCIDENTS** (Description / Date:) Auto Accidents: \_\_\_\_\_

Falls: \_\_\_\_\_ Head Injuries: \_\_\_\_\_

Broken Bones: \_\_\_\_\_ Dislocation: \_\_\_\_\_

Surgeries (Including Cosmetic): \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

**VITAMINS / HERBS / SUPPLEMENTS:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**LATE CANCELLATION / NO SHOW POLICY:** At Active Spinal and Sports Care, Inc. we emphasize quality Chiropractic and Healthcare services for our clients. Your well-being is important to us. Failure to provide our office with adequate notice of cancellation deprives another client from receiving care. If you wish to cancel or reschedule your appointment, we ask for at least 24 hours prior notification by phone to best assist those who may need of our services. Please note that our office charges at \$49 fee for any missed appointments with less than 24 hours' notice.

**INSURANCE AUTHORIZATION:** I understand that my insurance for treatment may NOT cover Active Release Therapy or soft tissue work, which is necessary for the full and proper resolution of my condition. I agree that I am responsible for this portion of my care, which would be an additional \$49 to my usual co-payment. I understand that decompression or PEMF are not covered by insurance and will be an additional \$85. Shockwave Therapy is also not covered by insurance and is \$105.

**ASSIGNMENT AND RELEASE:** I, the undersigned, assign directly to Active Spinal and Sports Care, Inc., Dr. Armen Agacanyan, D.C., Dr. Brianna Edginton, D.C., Dr. Adrian Galindo, D.C. and Dr. Riley Bransteter, D.C., all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am financially responsible for all charges for services rendered to me, whether or not paid by insurance and that payment is due at time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will immediately be due and payable. I clearly understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the clinic does not promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged. I further understand that the clinic will not enter a dispute with an insurance company for reimbursement or the amount of reimbursement. This is my obligation. I hereby authorize Active Spinal and Sports Care Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and/or requests pertaining to my physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and/or medical opinions. I certify to the best of my knowledge; the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

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**INFORMED CONSENT**

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapy techniques, for me (or the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, associated with, or serving as back-up for Dr. Armen Agacanyan, D.C., Dr. Brianna Edginton, D.C., Dr. Adrian Galindo, D.C. and Dr. Riley Bransteter, D.C.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment, including but not limited to: muscle sprains and strains, disc injuries, dislocations, broken bones and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based on the facts then known, are in my best interest. I understand that chiropractic treatments are generally considered safe and effective.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment. Armen B. Agacanyan, D.C., Brianna Edginton, D.C., Dr. Adrian Galindo, D.C., and Dr. Riley Bransteter, D.C., Active Spinal and Sports Care, Inc., 18525 Sutter Blvd., Suite 200, Morgan Hill, CA. 95037, 408-779-3565.

**Armen B. Agacanyan, D.C., M.S., Brianna Edginton, D.C., Adrian Galindo, D.C., and Dr. Riley Bransteter, D.C.  
Active Spinal & Sports Care, Inc.  
18525 Sutter Blvd. Suite 200  
Morgan Hill, CA. 95037  
408-779-3565**

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient's Guardian or Representative  
(If patient is a minor or incapacitated)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Facility Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Translator (if translation required)**

\_\_\_\_\_  
**Date**

## **ACTIVE SPINAL AND SPORTS CARE, INC.**

### **NOTICE OF PRIVACY PRACTICES**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY. Active Spinal & Sports Care, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

#### **Disclosure of Your Health Care Information**

**Treatment:** We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

*“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Active Spinal & Sports Care, Inc..”*

*“It is our policy to provide a substitute health care provider, authorized by Active Spinal & Sports Care, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”*

**Payment:** We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

*“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Active Spinal & Sports Care, Inc. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”*

**Workers’ Compensation:** We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

**Emergencies:** We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

**Public Health:** As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings:** We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement:** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons:** We may disclose your health information to coroners or medical examiners.

**Organ Donation:** We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Research:** We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

**Public Safety:** It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

**Specialized Government Agencies:** We may disclose your health information for military, national security, prisoner and government benefits purposes.

#### **Courtesy Calls to Your Residence:**

*“As a courtesy to our patients, it is our policy to send a text, email, or call your home 1-3 days prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information*

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*will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”*

**Change of Ownership:** In the event that Active Spinal & Sports Care, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights:**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Active Spinal & Sports Care, Inc. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Active Spinal & Sports Care, Inc. amend your protected health information. Please be advised, however, that Active Spinal & Sports Care, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Active Spinal & Sports Care, Inc.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Armen Agacanyan, D.C., Dr. Brianna Edginton, D.C. or Dr. Adrian Galindo, D.C. by calling this office at 408-779-3565. If Dr. Armen Agacanyan, Dr. Brianna Edginton, or Dr. Galindo is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints:** Complaints about your Privacy rights, or how Active Spinal and Sports Care, Inc. has handled your health information should be directed to Dr. Armen Agacanyan, D.C., Dr. Brianna Edginton, D.C., Dr. Adrian Galindo, D.C. or Dr. Riley Bransteter, D.C. by calling this office at 408-779-3565. If Dr. Armen Agacanyan, Dr. Brianna Edginton, or Dr. Galindo is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

This notice is effective as of 7/18/2022

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Active Spinal & Sports Care, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

\_\_\_\_\_  
Patient’s Name (print)

\_\_\_\_\_  
Patient’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date