Highest Health chiropractic

REACTIVATION PRACTICE MEMBER FORM

Name_____ Date of Birth ____ /____ /____ Date ____ /____ /____

Address_____City_____State_____ Zip_____

Phone_____ Email _____

Any changes to the following: □ Address □ Phone number □ Health Insurance □ Employment □ All Same
If so, please update:_____

Update The Health Concerns That Brought You Into This Office

Health Concern(s): List according to severity.	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:					
Second:					
Third:					

Is this injury the result of any type of accident? □ Yes □ No

Have you seen other doctors for these conditions since your last treatment? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

Any changes to the following since your last visit? □ Medications □ Surgeries □ Injuries □ Fractures □ No
If so, please describe:_____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

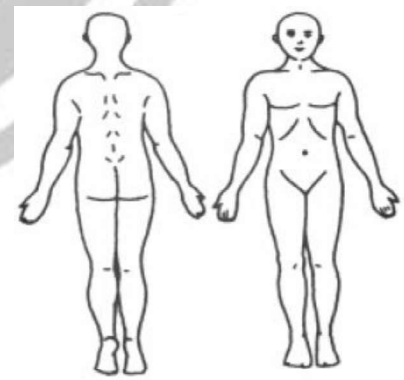
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms?

_____

What makes your symptoms feel worse?

_____



When is the problem(s) at its worst? → AM Mid-Day PM Late PM

Please circle those activities which are most affected by your current condition:

Sit to Stand	Climbing Stairs	Driving	Extended Computer Use	
Lifting Children	Dressing	Shaving	Household Chores	Reading
Sleep	Static Sitting	Static Standing	Sexual Activity	Garbage
Walking	Bathing	Yard Work	Sweep/Vacuum	Concentration

_____ _____-_____-_____

Practice Member or Authorized Person's Initials Date Completed

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Back pain Headaches _____ Worst possible pain

0 1 2 3 (4) 5 6 (7) 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. **What is your typical or AVERAGE pain?**

0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain level at its BEST? (How close to 0 does your pain get at its best?)**

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. **What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)**

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Highest Health Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

- By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Highest Health Chiropractic.

Signature: _____ Date: _____

NO CALL NO SHOW POLICY

In our office we reserve our time to serve you and your family. We understand that life happens, and appointments may need to be changed or canceled for emergent reasons. In this event we request that you give our office a call ASAP to change your scheduled appointment OR use your SKED appt. on your phone. We base our schedule and staffing needs on the anticipation of everybody making their appointments, making each scheduled appointment very important. Most importantly, it affects our committed practice members and others who rely on their scheduled time and who could have taken someone else's missed appointment spot. TWO "no call no shows" for regular adjustments are granted to a practice member in the event of an emergency, but there is no tolerance for chronic "no call no shows". Following the 3rd "no call no show" our billing department will automatically apply a $25 "no call no show" fee to the credit/debit card on file per family member at the end of the business day. For special appointment codes that require an evaluation room and a team member (Example: reevaluations, x-rays, Annual Health Reviews, etc.) our billing department will automatically apply a $25 "no call no show" fee to the credit/debit card on file per family member at the end of the business day for all missed special appointments. Ultimately, being consistent with your care will yield the best results for your health.

- I understand the above cancellation policy as well as the penalty fees that may be applied to my credit/debit card.

Acknowledge & Initial Here: _____

48- HOUR SPECIAL CODED APPOINTMENTS CANCELLATION/RESCHEDULING POLICY

At Highest Health Chiropractic, our goal is to help every Practice Member reach their highest level of health through consistent, personalized care. To keep our schedule running smoothly and ensure every Practice Member receives the attention they deserve, we require **48 hours' notice** for canceling or rescheduling special coded appointments (such as Evaluations or Annual Health Reviews). These appointments reserve extra time, team members, and resources. When they're canceled on short notice, it often leaves us unable to fill that spot — limiting care access for others.

- **48 Hours' Notice:** Cancellations or reschedules must be made at least 48 hours in advance.
- **Late Cancellations:** Appointments changed with less than 48 hours' notice will incur a **$25 fee**.
- **Emergencies Only:** Exceptions are made for emergencies, **determined at our team's discretion**.

Acknowledgment: I understand the 48-Hour Special Coded Appointment Cancellation/Rescheduling Policy and agree that a $25 fee may apply if I cancel or reschedule within 48 hours of my special coded appointment.

Acknowledge & Initial Here: _____