

# APPLICATION FOR CARE AT ALIGN YOUR SPINE CHIROPRACTIC

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ SSN#: \_\_\_\_\_  
Number of children and ages: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_  
Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

## REFERRAL:

Our clinic is primarily referral based. We would like to know who we can thank for sending you to us for help.  
Please let us know how you heard about our clinic. \_\_\_\_\_

Have you ever been under chiropractic care? \_\_\_\_\_

RATE THE IMPORTANCE OF YOUR HEALTH ON A SCALE OF 1-10: (Least) 1 2 3 4 5 6 7 8 9 10 (Most)

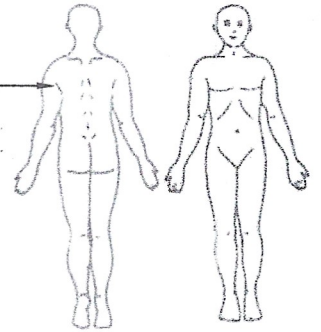
Are there any hobbies or interests that you would like to be able to do again?  
\_\_\_\_\_

## Your Top 3 Health Concerns, Goals or Problems (Mark on the body where you experience symptoms)

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_ *Mark on the body where you experience symptoms*

Third: \_\_\_\_\_



With 10 being the most severe and 0 being normal, rate your above concerns by *circling the number*:

Primary or chief complaint is: 0-1-2-3-4-5-6-7-8-9-10  
Second complaint is: 0-1-2-3-4-5-6-7-8-9-10  
Third complaint is: 0-1-2-3-4-5-6-7-8-9-10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM  
How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week

Has this condition ever been treated by anyone in the past?  No  Yes If yes, when: \_\_\_\_\_ by whom? \_\_\_\_\_

How long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_

What relieves your symptoms? \_\_\_\_\_ What makes your symptoms feel worse? \_\_\_\_\_

## YOUR PAST HISTORY

Please identify any and all types of jobs you have had in the past:  
\_\_\_\_\_

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions: \_\_\_\_\_

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES & SURGERIES→		
SCARS ON BODY→		
ALL DISEASES IN LIFE→		

**SOCIAL HISTORY**

- 1. **Smoking:**  cigars  pipe  cigarettes How often?  Daily  Weekends  Occasionally  Never
- 2. **Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never
- 3. **Recreational Drug use:**  Daily  Weekends  Occasionally  Never
- 4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect?

**FAMILY HISTORY:**

- 1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
If yes whom:  grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- 2. Any other hereditary conditions the doctor should be aware of?  No  Yes: \_\_\_\_\_

**I acknowledge the value and office-time-commitment required for my appointments; should I need to cancel (within 24hrs) or no-show for any appointment I am responsible for the fee associated with that appointment in its entirety.**

**Initial here:** \_\_\_\_\_

I consent and agree to allow this office to treat me, or my child, and use their Patient Health Information for the purpose of treatment, payment, healthcare operations, sharing of testimonials and coordination of care. \_\_\_\_\_ (Initial)

I authorize payment to be made directly to Align Your Spine Chiropractic, LLC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize use of this application for the purpose of processing claims, effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Align Your Spine Chiropractic, LLC for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**