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?

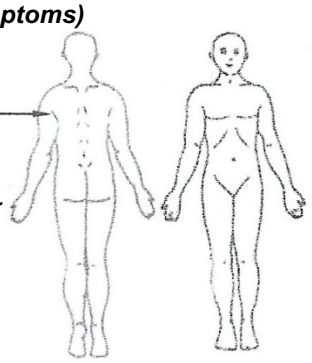
_____

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 O 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 PIVI

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 any one 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? _____

YOURPAST 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 PAS**T and any **CURRENT** conditions you feel may be contributing to your present problem:

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

SOCIAL HISTORY

Smoking: ☐ cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect?_____

FAMILY HISTORY:

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

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