APPLICATION FOR CARE AT ALIGN YOUR SPINE CHIROPRACTIC-LOUISVILLE

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address for Doctor Correspondence: _____ Phone: _____

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?

_____

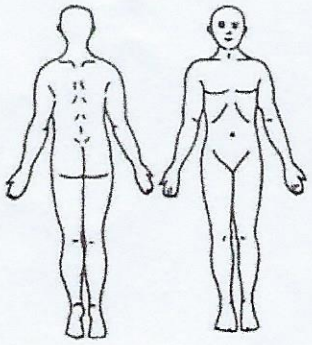
Your Top 3 Health Concerns, Goals or Problems

Primary: _____

Secondary: _____

Third: _____

Mark on the body where you experience symptoms:



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 here:_____

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**