

Align Care Chiropractic Center

Patient Information

Date: _____ Patient # _____

Name: _____ Social Security # _____ Home Phone: _____

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

E-mail address: _____ Fax # _____ Cell Phone: _____

Age: _____ DOB: _____ Gender: M F Marital: _____
Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Women—Are you pregnant? Y N How many weeks? _____

Name of Nearest Relative: _____ Relationship: _____ Phone: _____

How were you referred to our office? Newspaper Patient Referral MD Referral Other Advertising

Have you been treated by a chiropractor before? Y N Comments: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

Family Medical Doctor: _____ City: _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

PATIENT NAME _____ DATE _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: _____

Secondary Complaint: _____

Date symptoms appeared or accident happened: _____

Is this due to: ""Auto "York "Other _____?

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

	N = Now	P = Previously
Alcoholism	_____	Irritability _____
Back Pain	_____	Joint Pain/ Swelling _____
Breathing Problems	_____	Lights Bother Eyes _____
Broken Bones/ Fractures	_____	Loss of Balance _____
Cancer	_____	Loss of Memory _____
Chest Pains/ Tightness	_____	Loss of Smell _____
Circulation Problems	_____	Loss of Taste _____
Congenital Condition	_____	Low Blood Pressure _____
Constipation	_____	Menstrual Difficulties _____
Coughing Blood	_____	Muscle Spasms _____
Depression	_____	Neck Pain _____
Diabetes	_____	Nervousness _____
Diarrhea	_____	Numbness in Fingers _____
Difficulty Urinating	_____	Numbness in Toes _____
Dizziness	_____	Osteoarthritis _____
Drug Addiction	_____	Osteoporosis _____
Eating Disorder	_____	Pacemaker _____
Fainting	_____	Rheumatoid Arthritis _____
Fatigue	_____	Ringing or Buzzing in Ears _____
Feet Cold	_____	Ruptures _____
Fever	_____	Seizures/Epilepsy _____
Frequent Colds	_____	Shoulder/Arm Pain _____
Gall Bladder Problems	_____	Sinus Problems _____
Hands Cold	_____	Stiff Neck _____
Headaches _____ Frequency	_____	Stroke _____
Heart Disease	_____	Tension _____
High Blood Pressure	_____	Ulcers _____
HIV Positive	_____	Weakness in Extremities _____
Indigestion Problems	_____	Weight Loss/Gain _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify) _____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)	SISTERS	CHILDREN
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____ Date: _____