ALIGN TO HEALTH
NEW PATIENT INFORMATION

Name_____ ☐Female ☐Male Date ____/____/_____

What you prefer to be called _____ Age_____ DOB____/____/_____

Address _____City_____ State_____ Zip_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Email Address _____SS#_____

Employer _____Occupation_____Work Phone_____

Emergency Contact _____Relation _____Phone _____

How did you hear about our office? _____

Did you come here for a specific symptom or for wellness care? _____

_____

Have you had the same or similar symptoms before? ☐Yes ☐No Date of prior condition_____

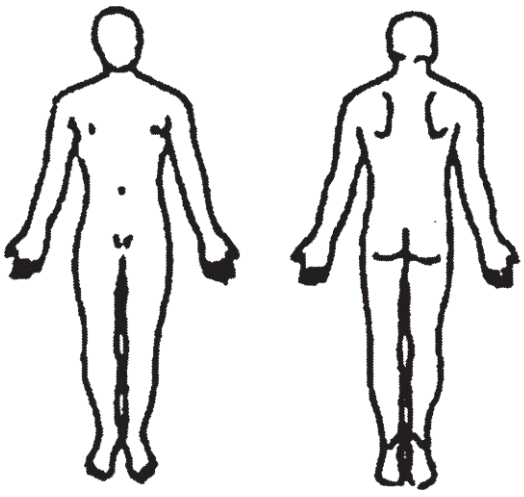
List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Mark Areas of Pain on Figures Below



Have you received chiropractic care before? ☐Yes ☐No

Family Physician/ PCP (Name and Phone): _____

_____

Allergies (Medicine, Food, Environment)

_____

_____

Previous Surgeries _____

Other serious illnesses_____

_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	heart disease	☐	☐	☐	polio	☐	☐	☐	hepatitis
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	cancer
☐	☐	☐	arthritis	☐	☐	☐	tuberculosis	☐	☐	☐	kidney disorder
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	rheumatic fever
☐	☐	☐	diabetes	☐	☐	☐	rheumatism	☐	☐	☐	HIV/ARC
☐	☐	☐	scarlet fever	☐	☐	☐	multiple sclerosis				
☐	☐	☐	stroke	☐	☐	☐	high blood pressure				
☐	☐	☐	muscular dystrophy	Other serious illness:_____							

Women Only:

Are you pregnant? ☐ Yes ☐ No

Health Insurance (Medicare Only):

Policyholder Name _____

Date of Birth: _____/_____/_____

INSURANCE INFORMATION AND CONSENT TO PROFESSIONAL SERVICES

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Align to Health to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage, and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures.

Patient's or Guardian's Signature_____ Date _____/_____/_____

ALIGN TO HEALTH
CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor, _____, age_____, do hereby authorize, request, and direct Align to Health to perform examinations, diagnostic x-rays, and any treatment that, in their judgment, is deemed advisable or necessary.

It is the understanding of the undersigned that the physician and his staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____

Date Signed _____/_____/_____

PATIENT NAME:_____ DOB____/____/_____

PLEASE CIRCLE YES IF YOU HAVE ANY OF THESE CONDITIONS CURRENTLY

GASTROINTESTINAL			***EARS, NOSE, THROAT***			***NEUROLOGICAL***		
Nausea	NO	YES	Sore Throat	NO	YES	SEIZURES	NO	YES
Vomiting	NO	YES	Hoarseness	NO	YES	HEADACHES	NO	YES
Heartburn	NO	YES	Ear Pain	NO	YES	Dizziness	NO	YES
Painful Swallowing	NO	YES	***CARDIOVASCULAR***			***DERMATOLOGY***		
Vomiting Blood	NO	YES	Abnormal Heart Beat	NO	YES	Rash	NO	YES
Black Stool	NO	YES	Chest Pain	NO	YES	Itching	NO	YES
Red Blood in Stool	NO	YES	Palpitations	NO	YES	Wounds	NO	YES
Abdominal Pain	NO	YES	Swelling Feet	NO	YES	***Musculoskeletal***		
Constipation	NO	YES	***RESPIRATORY***			Joint Pain	NO	YES
Diarrhea	NO	YES	Cough	NO	YES	Arthritis	NO	YES
Loss of Appetite	NO	YES	Shortness of Breath	NO	YES	Weakness	NO	YES
Bloating	NO	YES	Wheezing	NO	YES	***Psychiatric***		
CONSTITUTIONAL			Phlegm	NO	YES	Depression	NO	YES
						Anxiety	NO	YES
						Bipolar	NO	YES
			GENITOURINARY					
Recent Weight Gain	NO	YES	Frequent Urination	NO	YES			
# of Pounds			Kidney Failure	NO	YES			
Recent Weight Loss	NO	YES	OR Dialysis					
# of Pounds			Painful Urination	NO	YES			
Fever	NO	YES	Date of Last Menstrual					
Fatigue	NO	YES	Period _____					
Chills	NO	YES						

PATIENT NAME:_____ DOB____/____/_____

Please list all medications, vitamins, and nutritional supplements that you are currently taking:

Medication/Vitamin/Supplement	Dosage	Reason for Taking

ALIGN TO HEALTH

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

ALIGN TO HEALTH
CANCELLATION & NO-SHOW POLICY

CANCELLATION POLICY

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please inform Align to Health as soon as you know you will not be able to make your appointment. We respectfully request 24-hr notice in the event you are unable to keep your scheduled appointment. Failure to do so more than once will result in the patient needing to pay the amount that would have been collected at their scheduled visit ($50).

We understand that 24-hour notice is not always possible due to unforeseen/emergency circumstances and will make exceptions for these special circumstances.

NO-SHOW POLICY

The first missed appointment will be noted, but all fees will be waived. All future missed appointments will result in a $50 fee.

☐ I have read and agree to the policies outlined above.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature