ALIGN
SPORT & SPINE

NEW PATIENT

Date:_____

First Name _____ Middle Name _____Last Name _____

Name you preferred to be called _____

SSN_____ Date of Birth____/____/_____ Sex: __ Male __Female

Marital Status: __ Single __ Married __ Divorced __ Widowed

Spouse Name _____ # of Children _____ Cell # (____) _____

Work # (____)_____ Home # (____) _____

Mailing Address _____ City _____ State_____

Zip _____ Email _____

Employment Status: __ Employed __Unemployed __ Student __ Retired

Employer _____ Job Duties _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone (___)_____

Who referred you to our office? _____

Have you been under Chiropractic care before? __Yes __No If yes, when was last visit?_____

What is the reason for your visit today?

_____

_____

When did this concern begin? _____Was there an accident/injury? __ Yes __No

If yes, explain _____

Has this concern occurred before? Yes No If yes, explain _____

Have you had any other treatment for this concern? __ Yes __ No If yes, explain:

_____

_____

Do you currently try to "pop" your own neck or back? __ Yes __ No Have someone else do it? __Yes __No

Do you feel grinding, popping or clicking in your neck or back on movement? __ Yes __ No

Are you experiencing any limitations or restrictions in your activities of daily living (ex. Poor Sleep, Unable to exercise)? If so, explain _____

_____

Do you currently have any other health issues? __Yes __No If yes, please list those current health conditions: _____

_____

Which word describes the frequency of your discomfort? (select one)

___ Constant ___ Intermittent ___ Occasional ___ Rare

What helps relieve your discomfort? (select one or more)

___ Ice ___ Heat ___ Medication Other (please describe)_____

Where applicable, specify the approximate date of your most recent: (Month/Year)

Physical Exam:	____/____	Dental X-rays:	____/____
Spinal X-ray:	____/____	CT Scan:	____/____
MRI:	____/____	Other X-rays:	____/____

WOMEN ONLY:

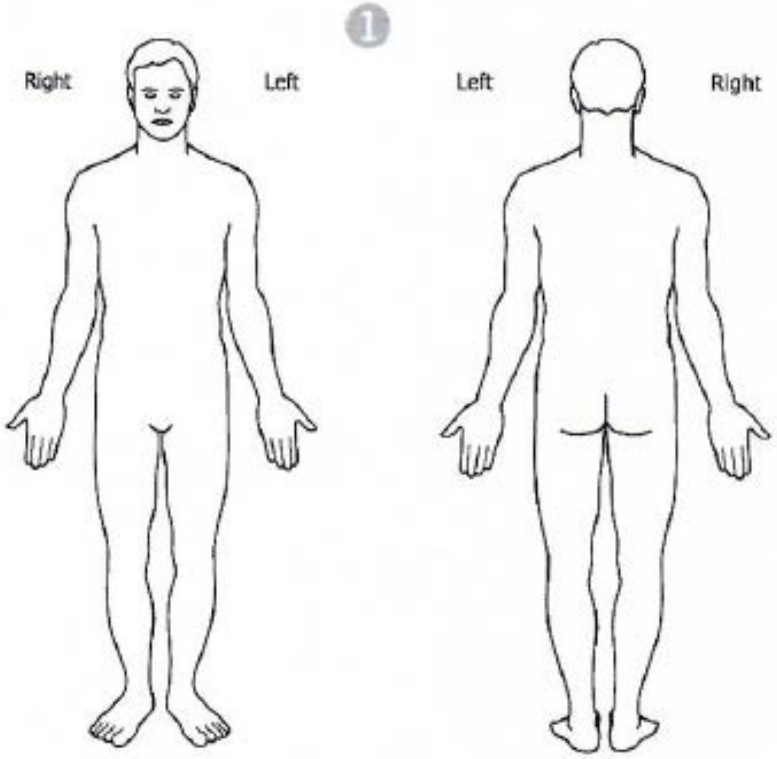
Are you pregnant? __Yes __No Are you taking birth control? __Yes __No Do you take HRT? __Yes __No

Are you nursing? __ Yes __ No Painful periods? __ Yes __ No Do you have breast implants? __ Yes __ No

Patient Symptom Illustrator

Patient Symptom Illustrator

Front Back



Instructions:

1. Identify your areas of discomfort by marking the affected body parts in the illustration.
2. Indicate the area name along with your specific symptoms associated with each selected area.
3. Rate your discomfort associated with each selected area.

		2 Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	3 0 = No Discomfort 10 = Severe Discomfort
Ex.	L (R) Lower Back			X			X			X	0 1 2 3 4 5 6 X 8 9 10
1.	L R										0 1 2 3 4 5 6 7 8 9 10
2.	L R										0 1 2 3 4 5 6 7 8 9 10
3.	L R										0 1 2 3 4 5 6 7 8 9 10
4.	L R										0 1 2 3 4 5 6 7 8 9 10

I certify that I am the patient, or legal guardian of the patient, listed on this intake form. I certify the above information to be true and accurate to the best of my knowledge.

Printed Name_____ Signature_____