Align Chiropractic and Wellness Center Patient Health History

How did you hear about our office?_____ Referred By_____

First Name _____Nick Name_____

Last Name_____ Middle Name_____ Suffix_____

Address 1_____

Address 2_____

City_____ State_____ Zip Code_____

Home Phone_____ Mobile Phone_____

Home email_____

* Your email will NOT be shared with any 3rd parties, only used for occasional office announcements and promotions.

Preferred Contact Method (check one)

☐ Home Phone ☐ Mobile Phone ☐ Home Email

Date of Birth:_____ Gender (check one) Male ☐ Female ☐ Unspecified ☐

Marital Status (check one) Single☐ Married☐ Other☐

Number of Children _____ Are you currently Pregnant _____

Is there any reason why you would not be able to lay face down to be examined and treated by the doctor? Yes☐ No ☐

If yes: what limitations? _____

Employment Status (check one)

☐ Employed _____ ☐Student ☐ Other ☐Retired ☐Self Employed
(Occupation?)

Do you have insurance? (check one) Yes ☐ No ☐

Do you currently smoke tobacco? ☐ Yes ☐ Former smoker ☐ Never been a smoker.

Do you currently drink alcoholic beverage of any kind? ☐ Yes ☐ Former drinker ☐Never been a drinker

Do you exercise? _____

If yes, how often and what type?_____

_____

Current medications including frequency and dosage if known.
If there are no current medications check here

1.	Start Date
2.	
3.	
4.	

5.	Start Date
6.	
7.	
8.	

Current vitamins, including frequency and dosage if known. _____

_____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? Yes ☐ No ☐

If yes, describe:

_____

Has any doctor diagnosed you with Diabetes presently? Yes ☐ No ☐

If yes, what kind? Type I ☐ Type II ☐

If yes to Diabetes, was your blood lab-work test for hemoglobin Alc > 9.0%? Yes ☐ No ☐ Not Sure ☐

If yes, other comments regarding Diabetes: _____

Have you had any X-rays, CT scans or MRI's in the past year? Yes ☐ No ☐

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History of Complaint

Please identify the condition(s) that brought you to this office:

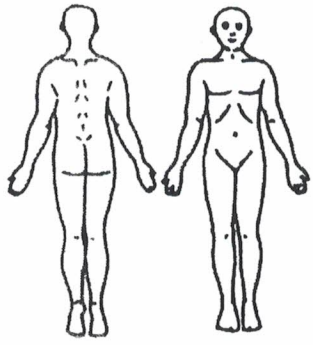
Primarily: _____ Secondarily: _____
Third: _____ Fourth: _____

Instructions: Please circle the number that best describes the questions being asked.
What is your pain right now? : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What is your typical pain? : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What is your pain at its best? : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
What is your pain at its worst? : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When and how did the problem(s) begin? _____
When is the problem at its worst? AM PM mid-day late PM
What is the frequency of discomfort? Continuous Intermittent Occasional Frequent
Was the condition treated by anyone in the past? Yes ❑ No ❑
If yes by whom?_____ What were the results?_____
Have you ever seen a chiropractor? Yes ❑ No ❑

***PLEASE MARK** the areas on the
diagram with the following **letters** to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching, DP = Deep, C = Cramping, SF = Stiffness
N = Numbness S = Sharp, ST = Stabbing, T= Tingling, TH = Throbbing

My condition is a result of:
[ ] Prolonged Position [ ] Prolonged Activity
[ ] Over exertion [ ] Awkward Motion
[ ] A worsening long-term problem
[ ] An accident or injury: [ ] Work [ ] Auto
[ ] Other:_____
What makes it feel worse? _____
What makes it feel better? _____



Activities of Daily Life: Please identify how your current condition is affecting your ability
to carry out activities that are routinely part of your life:

Lifting Objects ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Sit to Stand ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Climbing Stairs ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Concentration ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Household Chores ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Grooming ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Bending Over ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Sleep ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Sitting ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Standing ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform
Walking ☐ No Effect ☐ Mild Effect ☐ Moderate Effect ☐ Unable to Perform

What are you goals for care in our office?
[ ] I just want relief of my immediate pain
[ ] I would like to address the underlying problem.
[ ] I am interested in being the healthiest I can be and learning how to stay that way.
[ ] Other: _____

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Review of Systems

Please check any of the following you may have had or have

Musculoskeletal
[ ] Osteoporosis [ ] Arthritis [ ] Scoliosis [ ] Neck pain [ ] Back pain
[ ] Hip disorders [ ] Knee problems [ ] Foot/ankle [ ] Shoulder issues [ ] Elbow/wrist issues
[ ] TMJ issues [ ] Poor posture

Neurological
[ ] Anxiety [ ] Depression [ ] Dizziness [ ] Pins & needles [ ] Numbness

Cardiovascular
[ ] High blood pressure [ ] Low blood pressure [ ] High cholesterol
[ ] Poor circulation [ ] Excessive bruising [ ] Angina

Respiratory
[ ] Asthma [ ] Sleep apnea [ ] Emphysema [ ] Hay fever
[ ] Pneumonia [ ] Shortness of breath

Digestive
[ ] Anorexia [ ] Bulimia [ ] Food sensitivities [ ] Heartburn
[ ] Constipation [ ] Diarrhea

Sensory
[ ] Blurred vision [ ] Ears ringing [ ] Hearing loss [ ] Chronic ear infection
[ ] Loss of smell [ ] Loss of taste

Integumentary
[ ] Skin cancer [ ] Psoriasis [ ] Eczema [ ] Acne
[ ] Rash [ ] Hair loss

Endocrine
[ ] Thyroid issues [ ] Immune disorders [ ] Hypoglycemia [ ] Frequent infection
[ ] Swollen glands [ ] Low energy

Genitourinary
[ ] Kidney stones [ ] Infertility [ ] Frequent urination [ ] Prostate issues
[ ] Erectile dysfunction [ ] PMS symptoms

Constitutional
[ ] Fainting [ ] Low libido [ ] Poor appetite [ ] Fatigue [ ] Weakness
[ ] Sudden weight loss or gain (circle one)

Does anyone in your family suffer with the same condition(s)? No Yes
If yes whom: grandmother grandfather mother father sisters brothers sons daughters
What type of condition:

_____

Any other hereditary conditions the doctor should be aware of? No Yes:

_____

Have you ever seen a chiropractor before? Yes No
If yes, Whom? _____
What was your experience? _____

What position do you sleep in? [ ] side [ ] back [ ] stomach [ ] sitting
Is there anything else you'd like the doctor to be aware of?_____

Are you wearing Heel Lifts ( ) Arch Supports ( )

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Please list any major injuries, illnesses, surgeries and treatments you may have had or have.

Illness	Operations	Treatments	Injuries
[ ] AIDS	[ ] Appendix	[ ] Acupuncture	[ ] Broken bone
[ ] Alcoholism	[ ] Bypass surgery	[ ] Antibiotics	[ ] Car accident
[ ] Allergies	[ ] Cancer	[ ] Chemotherapy	[ ] Knocked unconscious
[ ] Arteriosclerosis	[ ] Eye surgery	[ ] Chiropractic care	[ ] Spine disorder
[ ] Cancer	[ ] Hysterectomy	[ ] Dialysis	[ ] Nerve disorder
[ ] Chicken pox	[ ] Pacemaker	[ ] Herbs	[ ] Hernia
[ ] Diabetes	[ ] Spine: _____	[ ] Hormone replacement	
[ ] Epilepsy	[ ] Tonsillectomy	[ ] Inhaler	
[ ] Glaucoma	[ ] Vasectomy	[ ] Massage	
[ ] Gout	[ ] Physical therapy		
[ ] Heart disease	[ ] Hernia repair		
[ ] Hepatitis	[ ] Other:_____		
[ ]HIV Positive			

_____

[ ] Malaria
[ ]Measles
[ ] Multiple Sclerosis
[ ] Mumps
[ ] Polio
[ ] Rheumatic fever
[ ] Scarlet fever
[ ] Sexually transmitted disease
[ ] Stroke
[ ] Tuberculosis
[ ] Typhoid fever
[ ] Ulcers

Acknowledgements:
Initials_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing are from medicine and does not proclaim to cure any named disease or entity.
Initials_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement for any involved third parties.
Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I'm responsible for the payment of any covered or non-covered services that I receive.
Initials_____ I hereby authorize payment to be made directly to Dr. Joseph C. Shiver DC. for all benefits which may be payable under a healthcare plan or from any other collateral sources.
Initials_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Patient or Authorized Person's Signature Date Completed