Patient Intake Form

For Office Use Only

Date: ____________________

Acct #: ____________________

Patient Height ______________

Patient Weight ______________

Patient BMI ______________

Patient Blood Pressure ________

Race (circle only 1)

American Indian	Alaska Native
Asian	Caucasian
African American	Other Pacific Islander
Native Hawaiian	Other
Declined to State	

Ethnicity (circle only 1)

Declined to State	Hispanic or Latino
Not Hispanic or Latino	

Name: ______________________________________ Age: _____ Date: __________ Preferred Language: __________________

Address: ____________________________________ City: ____________ State: _________ Zip: __________

Phone:(H) ________________ (C)____________________ Fax: ______________ E-Mail: ______________

Date of Birth: ________________ Sex: ☐M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W # of Children: _______

Occupation: ________________ Employer: __________________ Telephone: (Work): __________Ext.____

Insured's Name: _______________________ Phone: ________________ Insured's Date of Birth: ____________

Spouse's Name: _______________________________ Spouse's Occupation: ____________________

Spouse's Employer: ____________________________ Spouse's Telephone (Work): __________________

Past Chiropractic Care: Yes No When? ______ Doctor's Name: ______________________________

Results: ____________________________________ Referred By: ________________________________

Insurance Company: ___________________________ Telephone: ___________________________________

Social Security Number: ________________________ Drivers License Number: ______________State: ______

Spouse's Insurance Company: ____________________ Telephone: _________________________________

Spouse's Social Security Number: ________________ Spouse's Driver's License Number: ________________

Emergency Contact: ________________ Relationship ________________ Contact Number ________________

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ______________________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ______________________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: ______________

Briefly describe the accident, injury or illness:____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

______________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

______________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for this condition:

❑Tests/Studies: ____________________

❑Medications: ____________________

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ____________________ Transported by? ❑Ambulance ❑Police ❑Other: ____________________

Date Admitted: ____________ Date Released: ____________ Length of Stay: ____________

List the hospital procedures received: ____________________

List symptoms you are experiencing today: Choose the severity level associated with each symptom

____________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ____________ To: ____________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ____________________

What type of work do you do? ____________________

____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No ____________________

____

List any past conditions you may have had: ____________________

HABITS

❑Current Every Day Smoker

❑Current Some Day Smoker

❑Former Smoker

❑Never Smoker

❑Drinking Alcohol: (Cups/day): _____

❑Coffee Cups/Day: _______

❑Soft Drink Bottles or Cans/Day: _____

❑Water Cups/Day: _______

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: ____________________

Are you currently taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

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Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR NOSE/THROAT	RESPIRATORY
❑ Allergy(What) ____	❑ Belching or Gas	❑ Asthma	❑ Chest Pain
_____	❑ Colon Trouble	❑ Deafness	❑ Chronic Cough
❑ Bronchitis	❑ Constipation	❑ Earache	❑ Difficulty Breathing
❑ Chills (Constant)	❑ Diarrhea	❑ Ear Discharge	❑ Spitting Blood

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____

ALIGN CHIROPRACTIC, PLLC
1003 E REELFOOT AVE., SUITE 4
UNION CITY, TN 38261 731-885-0461

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

For further information regarding this notice, please contact our Doctor at (731)885-0461