Welcome to Align!

Please complete the following:

Email Address:_____

Name_____ Date_____

Home Address_____City_____ State_____Zipcode_____

Primary Phone_____cell/home/work Secondary Phone_____cell/home/work

Occupation: _____Employer: _____

Emergency Contact_____ Phone_____

Insurance Company: _____Subscriber's Name: _____

Subscriber's DOB: ____/____/_____ Relationship to Subscriber: _____

Where have you heard about ALIGN? **(Please circle all that apply)**

Yelp	CitySearch	Insider Pages	Alignmyhealth.com	AcuFinder	Insurance Website	Walk/Drive by
Twitter	Facebook	Yellow pages	ChiroDirectory	Google	Beaverton Chamber	LocateaDoc

Referred By: _____ Local Event: _____ Other: _____

PATIENT INFORMATION

☐ Male ☐ Female Birth Date_____ Height_____ Weight_____ Marital Status: ☐ Single ☐ Married

Who is your primary medical doctor:_____ Phone #: _____ Date last examined: _____

Have you ever had any X-ray/MRI/CT imaging before? Y/N If so, when and which area?_____

Have you ever received acupuncture treatment before? ☐ Yes ☐ No Have you ever received chiropractic care before? ☐ Yes ☐ No

HEALTH HISTORY

What are the reasons you are seeking treatment today? Please limit to 1-5 and **explain the onset (cause, duration, etc.).**

Have you attempted any other forms of treatment for the above? If so, please describe, and rate their success.

Please list any allergies (seasonal, foods, pharmaceutical), food sensitivities or food cravings that you have.

Please list any major accidents, surgeries, or hospitalizations and include approximate dates.

Medications and supplements you are currently taking.

Medication/Supplement	***Reason***	***Dosage***	***How Long***	***Prescribed by***

Please **check** the box for any illnesses you or a blood relative (grandparent, parent, child, or sibling) have had or currently have:

	YOU	***RELATIVE***	***DATE DIAGNOSED***	***NOTES***
Arthritis (type)	☐	☐		
AIDS/HIV	☐	☐		
Cancer (type, stage)	☐	☐		
Diabetes (type)	☐	☐		
Emotional Disorders	☐	☐		
Heart Disease (type)	☐	☐		
Hepatitis (type)	☐	n/a		
High Blood Pressure	☐	☐		
Infectious Diseases	☐	n/a		
Rheumatic Fever	☐	n/a		
Seizures	☐	☐		
Stroke	☐	☐		
Tuberculosis	☐	n/a		
STD (Syphilis, HPV, Herpes, Gonorrhea, Chlamydia)	☐	☐		
Other	☐	☐		
Other	☐	☐		

Please **check** use and frequency/amount of the following:

	Yes	***Amount***	***Notes***
Coffee / Black tea	☐		
Recreational Drugs	☐		
Tobacco	☐		
Alcohol	☐		
Soda Pop	☐		
Water Intake	☐		
Exercise (describe)	☐		

Please indicate as follows: **Frequently experience** (3 or more times/week), **occasionally experience** (less than once/week) and **Circle Right, Left,** or both, as applicable.

	Freq.	Occas.
HEAD		
Headache	☐	☐
-entire head	☐	☐
-back of head (L/R)	☐	☐
-forehead	☐	☐
-temples (L/R)	☐	☐
-migraine	☐	☐
Head feels heavy	☐	☐
Hair loss	☐	☐
Memory loss	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Balance problems	☐	☐
Light bothers eyes	☐	☐
Diminished smell	☐	☐
Nasal congestion	☐	☐
Diminished taste	☐	☐
Impaired hearing (L/R)	☐	☐
Pain in ear (L/R)	☐	☐
Ringing in ear (L/R)	☐	☐
Buzzing in ear (L/R)	☐	☐
NECK		
Neck pain (L/R)	☐	☐
-worse with movement	☐	☐
Stiffness in neck (L/R)	☐	☐
Muscle spasms (L/R)	☐	☐
Popping in neck	☐	☐
SHOULDERS		
Pain in shoulder joint (L/R)	☐	☐
Pain across shoulder (L/R)	☐	☐
Shoulder joint stiffness (L/R)	☐	☐
Tension across shoulder (L/R)	☐	☐
Tingling across shoulder (L/R)	☐	☐
GENITOURINARY		
Hemorrhoids	☐	☐
Painful or cold genitalia	☐	☐
Blood in urine	☐	☐
Urinary retention	☐	☐
Pain with urination	☐	☐
Decreased sex drive	☐	☐
Kidney stones	☐	☐

	Freq.	Occas.
ARMS & HANDS		
Pain in upper arm (L/R)	☐	☐
Pain in forearm (L/R)	☐	☐
Pain in hand (L/R)	☐	☐
Tingling in arm (L/R)	☐	☐
Tingling in hand (L/R)	☐	☐
Numbness in arm (L/R)	☐	☐
Numbness in hand (L/R)	☐	☐
Cold hands	☐	☐
Swollen fingers (L/R)	☐	☐
Decreased grip strength (L/R)	☐	☐
Elbow pain (L/R)	☐	☐
Wrist pain (L/R)	☐	☐
MID BACK		
Mid back pain (L/R)	☐	☐
Pain b/w shoulder blades	☐	☐
Muscle spasms	☐	☐
Pain with deep breath	☐	☐
CHEST		
Chest pain (L/R)	☐	☐
Shortness of breath	☐	☐
Pain around ribs/sternum	☐	☐
Collarbone pain (L/R)	☐	☐
GASTROINTESTINAL		
Indigestion	☐	☐
Heartburn/Reflux	☐	☐
Bloating	☐	☐
Excessive appetite	☐	☐
Lack of appetite	☐	☐
Nausea/Vomiting	☐	☐
Gas	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Abdominal pain	☐	☐
Blood in stool	☐	☐
Gall stones	☐	☐
Colitis	☐	☐
Diverticulitis	☐	☐
Ulcer	☐	☐

	Freq.	Occas.
LOW BACK		
Low back pain	☐	☐
-worse with working	☐	☐
-worse with standing	☐	☐
-worse with lifting	☐	☐
-worse with bending	☐	☐
-worse with sitting	☐	☐
-worse with coughing/sneezing	☐	☐
Disc problems	☐	☐
Muscle spasms	☐	☐
HIPS, LEGS & FEET		
Pain in buttocks (L/R)	☐	☐
Pain in hip joint (L/R)	☐	☐
Pain down leg (L/R)	☐	☐
Pain down both legs	☐	☐
Leg cramps	☐	☐
Tingling in leg (L/R)	☐	☐
Tingling in foot (L/R)	☐	☐
Numbness in leg (L/R)	☐	☐
Numbness in foot (L/R)	☐	☐
Cold feet	☐	☐
Cramps in feet	☐	☐
Swollen ankles/feet	☐	☐
Knee pain (L/R)	☐	☐
Ankle pain (L/R)	☐	☐
Heel pain (L/R)	☐	☐
Foot pain (L/R)	☐	☐
GENERAL		
Anxiety/Nervousness	☐	☐
Irritability	☐	☐
Depression	☐	☐
Fatigue	☐	☐
Increased stress level	☐	☐
Lack of energy	☐	☐
Difficulty sleeping	☐	☐
Recent unexplained weight loss	☐	☐
Catch colds easily	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Jaundice (yellow skin or eyes)	☐	☐
Edema (swelling)	☐	☐
Soft or brittle nails	☐	☐

FEMALE

	Yes	*No*		*Yes*	*Notes*
Are you pregnant	☐	☐	Fibroids	☐	
Are you trying to get pregnant	☐	☐	Fibrocystic Breasts	☐	
Number of pregnancies			Endometriosis	☐	
Number of live births			Ovarian Cysts	☐	
Number of Miscarriages			PID	☐	
Number of Abortions			Other	☐	
Age of first period (menarche)			Number of days of flow		
Age of last period (menopause)			Number of days between periods		
Color of flow (light or dark)			Clots	☐	

Examination	*Date*	*Notes*
Last Gynecological Exam		
Last Mammogram		
Last Bone Density Exam		

Other Symptoms	*Yes*	*Notes*
Discharge	☐	
Nausea	☐	
Swollen breasts	☐	
Night Sweats	☐	
Insomnia	☐	
Vaginal dryness	☐	
Constipation	☐	
Mood Swings	☐	
Hot Flashes	☐	
Headaches	☐	

MALE

	Yes		*Yes*	*Notes*
Prostate Problems	☐	Dribbling	☐	
Rectal Dysfunction	☐	Testicular Pain	☐	
Incontinence	☐	Retention of Urine	☐	
Increased / Decreased libido	☐	Premature Ejaculation	☐	
Groin Pain	☐	Impotence	☐	

	Date/ Number	*Notes*
Date of Last Prostate Exam		
Lab Results		
Frequency of Urination Daytime		
Frequency of Urination Nighttime		

ALIGN Wellness Center
1675 SW Marlow Ave. Ste. 309
Portland, OR 97225
(503) 597-7780

CONSENT FOR EXAMINATION AND TREATMENT

I understand that ALIGN Wellness Center is a multidisciplinary healthcare facility. I acknowledge that during the course of my care, I (or the person named below, for whom I am legally responsible) may receive chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, acupuncture, cupping, and other traditional Chinese medicine procedures.

I understand that there are some risks inherent to treatment. I understand that, if I receive chiropractic, the most common risks are temporary aggravation of my condition and soreness. Rarer risks include, but are not limited to: fractures, stroke, dislocations, sprains, burns and aggravation of disc injury.

I understand that, if I receive acupuncture and associated treatments, the risks include, but are not limited to: minor bleeding, local bruising, fainting and temporary aggravation of prior existing symptoms.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests.

I have read, or had read to me, the above consent. By signing below, I agree to the above mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (please print) **Date**

_____

Signature of Patient (or Guardian if Patient is a Minor)

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FINANCIAL POLICY

ALIGN Wellness Center is committed to providing you with the best possible care. We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. Your insurance coverage is a contract between you, your employer, and the insurance company. We are not a party to the contract. All services rendered to you are your responsibility. However, we realize that insurance companies need processing time. All charges will become due and payable if the insurance company does not reimburse ALIGN Wellness Center within 45 days of services rendered.

Please familiarize yourself with your insurance policy and its requirements.

As a courtesy, ALIGN will bill your insurance company. All co-pays, estimated deductible or coinsurance amounts and uncovered services are due at the time of service.

I, _____, am responsible for all charges incurred, regardless of insurance coverage. In the event my account is referred to a collections agency due to lack of payment on my part, I agree to pay 100% of all collection/legal fees which will be added to my account.

Returned Checks: A **$25** insufficient funds fee will be charged to your account for each returned check.

Missed Appointment: In an effort to ensure all our patients have the opportunity to be seen when needed, a **$75** fee will be applied for missed or rescheduled appointments without 24 hour prior notice. Thank you for your understanding and consideration of others.

_____ _____

Patient's Name (please print) **Date**

_____

Signature of Patient (or Guardian if Patient is a Minor)

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AUTHORIZATION TO RELEASE INFORMATION

By completing and signing this form, you are authorizing ALIGN Wellness Center to release your health information to your insurance company for benefits verification and billing purposes or to release records to another provider or facility. This form may also be used to obtain records from another provider or facility on your behalf.

To Be Read and Signed by Patient

I understand the following:

I may revoke this authorization at any time by providing written notice to the practice. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage. The practice will not condition treatment or payment based on my signing this authorization. I acknowledge that I have had an opportunity to review this authorization and understand its purpose. I may request a copy of this authorization at any time.

"I hereby authorize ALIGN Wellness Center to make use and disclosure of my protected health information (information in my medical and/or financial records) as indicated below."

If you would like us to share information with a designated family member, provider or anyone else, please indicate to whom we may release this information and check which items may be released.

I _____ hereby give consent to _____ to access information concerning my selected records.

- ☐ Financial/ Insurance
- ☐ Schedule
- ☐ Medical
- ☐ Other (specify) _____

_____ _____

Patient's Name (please print) **Date**

_____

Signature of Patient (or Guardian if Patient is a Minor)