Welcome to Align - Please complete the following:

Email Address:_____

Name_____ Date_____

Home Address_____City_____ State_____Zipcode_____

Primary Phone_____ Secondary Phone_____

Occupation: _____ Employer: _____

Emergency Contact_____ Phone_____

Where have you heard about Align? **(Please check all that apply)**

☐ Yelp ☐ Google ☐ Insurance Website ☐ Facebook ☐ Walk/Drive by Referred By: _____

PATIENT INFORMATION

☐Male ☐Female Birth Date_____ Height_____ Weight_____

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? ☐Y ☐N Have you ever received chiropractic care before? ☐Y ☐N

HEALTH HISTORY

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

1)

2)

3)

4)

5)

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 select **Right, Left,** or **Both**, as applicable.

	Freq.	Occas.
HEAD		
Headache	☐	☐
-entire head	☐	☐
-back of head	☐	☐
-forehead	☐	☐
-temples	☐	☐
-migraine	☐	☐
Head feels heavy	☐	☐
Hair loss	☐	☐
Memory loss	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Balance problems	☐	☐
Light bothers eyes	☐	☐
Diminished smell	☐	☐
Nasal congestion	☐	☐
Diminished taste	☐	☐
Impaired hearing	☐	☐
Pain in ear	☐	☐
Ringing in ear	☐	☐
Buzzing in ear	☐	☐
NECK		
Neck pain	☐	☐
-worse with movement	☐	☐
Stiffness in neck	☐	☐
Muscle spasms	☐	☐
Popping in neck	☐	☐
SHOULDERS		
Pain in shoulder joint	☐	☐
Pain across shoulder	☐	☐
Shoulder joint stiffness	☐	☐
Tension across shoulder	☐	☐
Tingling across shoulder	☐	☐
GENITOURINARY		
Hemorrhoids	☐	☐
Painful or cold genitalia	☐	☐
Blood in urine	☐	☐
Urinary retention	☐	☐
Pain with urination	☐	☐
Decreased sex drive	☐	☐
Kidney stones	☐	☐
ARMS & HANDS		
Pain in upper arm	☐	☐
Pain in forearm	☐	☐
Pain in hand	☐	☐
Tingling in arm	☐	☐
Tingling in hand	☐	☐
Numbness in arm	☐	☐
Numbness in hand	☐	☐
Cold hands	☐	☐
Swollen fingers	☐	☐
Reduced grip strength	☐	☐
Elbow pain	☐	☐
Wrist pain	☐	☐
MID BACK		
Mid back pain	☐	☐
Pain b/w shoulder blades	☐	☐
Muscle spasms	☐	☐
Pain with deep breath	☐	☐
CHEST		
Chest pain	☐	☐
Shortness of breath	☐	☐
Pain around ribs/sternum	☐	☐
Collarbone pain	☐	☐
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	☐	☐
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	☐	☐
Pain in hip joint	☐	☐
Pain down leg	☐	☐
Pain down both legs	☐	☐
Leg cramps	☐	☐
Tingling in leg	☐	☐
Tingling in foot	☐	☐
Numbness in leg	☐	☐
Numbness in foot	☐	☐
Cold feet	☐	☐
Cramps in feet	☐	☐
Swollen ankles/feet	☐	☐
Knee pain	☐	☐
Ankle pain	☐	☐
Heel pain	☐	☐
Foot pain	☐	☐
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		