ALIGN HEALTH

NEW PATIENT APPLICATION FORM

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TODAY'S DATE: | DATE OF BIRTH:

NAME: ☐ MALE ☐ FEMALE | HEIGHT: | WEIGHT: | ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

ADDRESS: | CITY:

STATE: | ZIP: | HOME PHONE: | CELL:

SOCIAL SECURITY #: | EMAIL ADDRESS:

EMPLOYER'S NAME: | BUSINESS ADDRESS:

BUSINESS PHONE: | TYPE OF WORK:

SPOUSE'S NAME: | SPOUSE'S OCCUPATION: | AGES OF CHILDREN:

HOW DID YOU HEAR ABOUT US? ☐ FAMILY ☐ FRIEND ☐ WEB SITE ☐ YELLOW PAGES ☐ NEWSPAPER ☐ OTHER:________________

EMERGENCY CONTACT: | PHONE #:

ADDRESS: | RELATIONSHIP :

INSURANCE

INCLUDING YOUR SELF WHO IS RESPONSIBLE FOR YOUR BILL? ☐ WORKER'S COMP ☐ MEDICARE ☐ AUTO INSURANCE ☐ MEDICAL INSURANCE

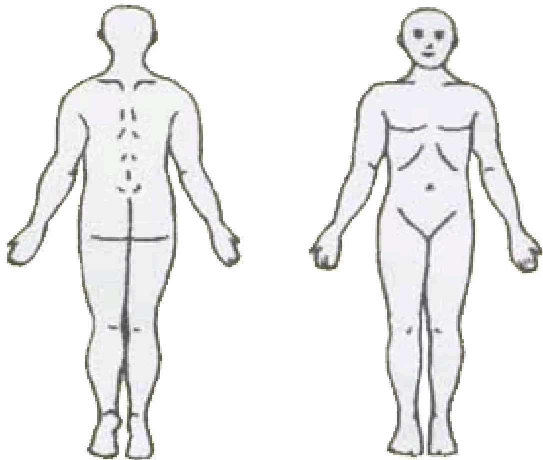
INSURANCE CARRIER: | HEALTH ID CARD #:

INSURED PERSON'S NAME: | GROUP #:

INSURED PERSON'S DATE OF BIRTH: | PRIMARY CARE PHYSICIAN:

INSURED PERSON'S ADDRESS:

CURRENT HEALTH PROFILE



Please circle areas of discomfort.

HEALTH PROBLEM: (WHY ARE YOU HERE TODAY?)

☐ NECK PAIN ☐ MID-BACK PAIN ☐ LOW-BACK PAIN
☐ HEADACHES ☐ ASTHMA ☐ HIP PAIN
☐ EAR INFECTIONS ☐ ALLERGIES ☐ CONSTIPATION
☐ ADD ☐ HEART BURN ☐ DIGESTIVE PROBLEMS
☐ CARPAL TUNNEL ☐ ACID REFLUX ☐ SCOLIOSIS

☐ OTHER:

CONDITION: ☐ NEW ☐ RECURRING

DATE OF INJURY:

MECHANISM OF ONSET: ☐ AUTO ☐ WORK ☐ FALL ☐ LIFTING ☐ OVER EXERTION ☐ REPETITIVE MOTION ☐ UNKNOWN ☐ SLEPT WRONG ☐ SPORTS INJURY ☐ NO INJURY ☐ OTHER

SYMPTOMS: ☐ PAIN ☐ NUMBNESS ☐ STIFFNESS ☐ WEAKNESS

QUALITY: ☐ BURNING ☐ DIFFUSE ☐ DULL/ACHE ☐ LOCALIZED ☐ SHARP ☐ SHOOTING ☐ STABBING ☐ THROBBING ☐ TIGHTNESS ☐ TINGLING ☐ RADIATING ☐ OTHER

INTENSITY:
ON A SCALE OF 0-10 (10 BEING THE WORST) RATE YOUR DISCOMFORT: 0 1 2 3 4 5 6 7 8 9 10

CURRENT HEALTH PROFILE (CON'T)

WHAT MAKES YOUR CONDITION BETTER? ☐ ACTIVITY ☐ BENDING ☐ COLD ☐ HEAT ☐ MASSAGE ☐ MOVEMENT ☐ OTC MEDS ☐ RX MEDS ☐ REST ☐ STRETCHING ☐ SITTING ☐ STANDING ☐ TWISTING ☐ WALKING ☐ NOTHING HELPS

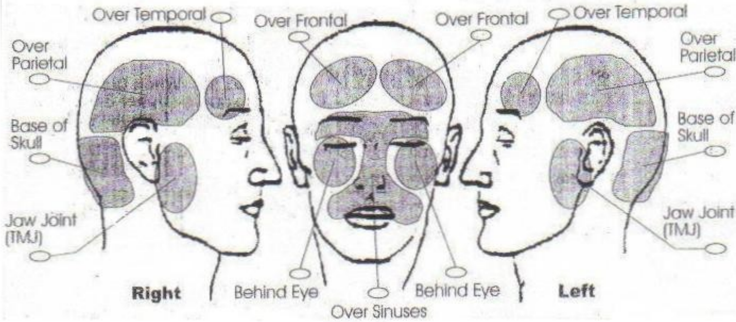
WHAT MAKES YOUR CONDITION WORSE? ☐ SNEEZING ☐ COUGHING ☐ BENDING ☐ LIFTING ☐ PULLING ☐ TWISTING ☐ STRETCHING ☐ WALKING ☐ SITTING ☐ STANDING ☐ STRAINING AT STOOL ☐ NOTHING

FREQUENCY OF PROBLEM: ☐ INTERMITTENT 0-25% ☐ OCCASIONAL 25 - 50% ☐ FREQUENT 50 - 75% ☐ CONSTANT 75 - 100%

TIMING WORSE IN THE: ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ W/ACTIVITY ☐ CONSTANT

HEADACHES

PLEASE MARK LOCATION OF HEADACHE(S)



WHEN DOES YOUR HEADACHE USUALLY START? ☐ MORNING ☐ AFTERNOON ☐ NIGHT

WHAT SEEMS TO BRING ON YOUR HEADACHES? ☐ ACTIVITY ☐ STRESS ☐ ALCOHOL ☐ CAFFEINE ☐ FOODS ☐ MENSTRUAL PERIOD

QUALITY OF HEADACHES: ☐ DULL ☐ SHARP ☐ THROBBING ☐ STABBING ☐ AURA ☐ NO AURA

HOW OFTEN DO THEY OCCUR?

TIMES/WEEK: 0 1 2 3 4 5 6 7 8 9 10

TIMES/MONTH: 0 1 2 3 4 5 6 7 8 9 10

EMPLOYMENT

OCCUPATION:

WORK (HRS/DAY):

JOB CLASSIFICATION: ☐ SITTING ☐ LIGHT ☐ MODERATE ☐ HEAVY LIFTING

LIFTING FREQUENCY: ☐ OCCASIONAL 0 - 32% ☐ FREQUENT 33 - 65% ☐ CONSTANT 66 - 100%

WORK ACTIVITY POSTURES: (HRS/DAY): ☐ SITTING ☐ STANDING ☐ WALKING ☐ CLIMBING ☐ PUSHING ☐ PULLING ☐ KNEELING ☐ REACHING ☐ TWISTING ☐ BENDING

REPETITIVE ACTIVITIES (HRS/DAY): ☐ COMPUTER ☐ PHONE ☐ MACHINERY ☐ HAND TOOLS ☐ ASSEMBLY ☐ GRASPING

IMPACT ON LIFE

HOW DOES THIS CONDITION EFFECT JOB PERFORMANCE? ☐ MILD PAINFUL (CAN DO) ☐ MODERATE PAIN (LIMITED) ☐ SEVERE (UNABLE TO PERFORM) ☐ OTHER (EXPLAIN):

THIS CONDITION PREVENTS ME FROM PERFORMING THESE ACTIVITIES

ACTIVITY (place a check in column)	NO EFFECT	MILD (CAN DO)	MODERATE (LIMITED)	SEVERE (UNABLE TO DO)	ACTIVITY (place a check in column applicable)	NO EFFECT	MILD	MODERATE	SEVERE
Bending					Reading (concentration)				
Carrying Groceries					Running				
Change Positions					Self Care—Dressing				
Child Care					Self Care—Bathing				
Climb Stairs					Sexual Activities				
Computer Use					Sleep				
Daily Pet Care					Static Sitting				
Driving					Static Standing				
Exercise					Swimming				
Golf					Walking				
Household					Weight Lifting				
Lifting					Yard Work				

THIS CONDITION IS AFFECTING MY: ☐ JOB ☐ MARRIAGE ☐ FINANCES ☐ OTHER (EXPLAIN):

HELPING THIS CONDITION WOULD INCREASE MY QUALITY OF LIFE BY: ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes.

☐ **Relief** ☐ **Correction of the cause** ☐ **Prevention** ☐ **Let the Doctor choose for me**

Below is a list of diseases that may seem unrelated to the purpose of your appointment.
However, these questions must be answered carefully as the problems can affect your overall course of care.
REVIEW OF SYMPTOMS—Please fill out all of the sections, even if "DENY".

CONSTITUTIONAL
☐ I DENY ANY **CONSTITUTIONAL** ISSUE(S)
☐ CHILLS ☐ WEIGHT GAIN ☐ WEIGHT LOSS ☐ FEVER
☐ NIGHT SWEATS ☐ DAYTIME DROWSINESS ☐ FATIGUE

EYE/VISION
☐ I DENY ANY **EYE/VISION** ISSUE(S)
☐ BLINDNESS ☐ EYE PAIN ☐ TEARING ☐ FIELD CUTS (VISUAL FIELD DEFECT) ☐ CATARACTS ☐ CHANGE IN VISION ☐ WEAR GLASSES
☐ DOUBLE VISION ☐ PHOTOPHOBIA ☐ BLURRED VISION ☐ GLAUCOMA ☐ ITCHING ☐ CONTACT LENSES

EARS, NOSE & THROAT
☐ I DENY ANY **E/N/T** ISSUE(S)
☐ BLEEDING ☐ FAINTING ☐ NASAL CONGESTION ☐ EAR DRAINAGE ☐ POST NASAL DRIP ☐ HOARSENESS
☐ DISCHARGE ☐ HEADACHES ☐ SINUS INFECTIONS ☐ EAR INFECTIONS ☐ DIFFICULTY SWALLOWING ☐ RHINORRHEA (RUNNY NOSE)
☐ DIZZINESS ☐ LOSS OF SMELL ☐ DENTAL IMPLANTS ☐ HEARING LOSS ☐ EAR PAIN ☐ SINUS INFECTION
☐ SNORING ☐ SORE THROATS (FREQUENT) ☐ TINNITUS (RINGING IN EARS) ☐ TMJ PROBLEMS

RESPIRATION:
☐ I DENY ANY **RESPIRATORY** ISSUE(S)
☐ ASTHMA ☐ COUGHING UP BLOOD ☐ SPUTUM PRODUCTION ☐ COUGH ☐ SHORTNESS OF BREATH ☐ WHEEZING

CARDIOVASCULAR
☐ I DENY ANY **CARDIOVASCULAR** ISSUE(S)
☐ ANGINA (CHEST PAIN OR DISCOMFORT) ☐ HEART MURMUR ☐ PALPITATIONS (IRREGULAR OR FORCEFUL BEATING OF THE HEART) ☐ SWELLING OF LEGS
☐ CHEST PAIN ☐ HEART PROBLEMS ☐ ULCERS
☐ CLAUDICATION (LEG PAIN OR ACHINESS ☐ ORTHOPNEA (DIFFICULTY BREATHING WHILE LAYING DOWN) ☐ PAROXYMSAL NOCTURNAL DYSPNEA (WAKING AT NIGHT WITH SHORTNESS OF BREATH) ☐ VARICOSE VEINS

GASTROINTESTINAL
☐ I DENY ANY **GASTROINTESTINAL** ISSUE(S)
☐ ABDOMINAL PAIN ☐ DIARRHEA ☐ INDIGESTION ☐ ABNORMAL STOOL CALIBER ☐ VOMITING BLOOD
☐ BELCHING ☐ DIFFICULTY SWALLOWING ☐ JAUNDICE (YELLOWING OF ☐ ABNORMAL STOOL COLOR
☐ BLACK, TARRY ☐ HEARTBURN ☐ NAUSEA ☐ ABNORMAL STOOL CONSISTENCY
☐ CONSTIPATION ☐ HEMORRHOIDS ☐ RECTAL BLEEDING ☐ VOMITING

FEMALE
☐ I DENY ANY **FEMALE** ISSUE(S)
☐ BIRTH CONTROL THERAPY ☐ CRAMPS ☐ IRREGULAR MENSTRUATION ☐ VAGINAL DISCHARGE
☐ BREAST LUMP/PAIN ☐ FREQUENT URINATION ☐ URINE RETENTION
☐ BURNING URINATION ☐ HORMONE THERAPY ☐ VAGINAL BLEEDING

MALE
☐ I DENY ANY **MALE** ISSUE(S)
☐ BURNING URINATION ☐ ERECTILE DYSFUNCTION ☐ FREQUENT URINATION ☐ HESITANCY/DRIBBLING
☐ PROSTATE PROBLEMS ☐ URINE RETENTION

ENDOCRINE
☐ I DENY ANY **ENDOCRINE** ISSUE(S)
☐ COLD INTOLERANCE ☐ EXCESSIVE APPETITE ☐ EXCESSIVE THIRST ☐ GOITER ☐ HEAT INTOLERANCE ☐ VOICE CHANGES
☐ DIABETES ☐ EXCESSIVE HUNGER ☐ FREQUENT URINATION ☐ HAIR LOSS ☐ UNUSUAL HAIR GROWTH

SKIN
☐ I DENY ANY **SKIN** ISSUE(S)
☐ CHANGES IN NAIL TEXTURE ☐ HAIR GROWTH ☐ HIVES ☐ PARESTHESIA (NUMBNESS, PRICKLING, OR TINGLING) ☐ RASH ☐ SKIN LESIONS/ULCERS
☐ CHANGES IN SKIN COLOR ☐ HAIR LOSS ☐ ITCHING ☐ HISTORY OF SKIN DISORDERS ☐ VARICOSITIES

NERVOUS SYSTEM
☐ I DENY ANY **NERVOUS** SYSTEM ISSUES
☐ DIZZINESS ☐ HEADACHES ☐ LOSS OF CONSCIOUSNESS ☐ NUMBNESS ☐ SLEEP DISTURBANCE ☐ STROKES ☐ UNSTEADINESS OF GAIT
☐ FACIAL WEAKNESS ☐ LIMB WEAKNESS ☐ LOSS OF MEMORY ☐ SEIZURES ☐ STRESS ☐ TREMORS

PSYCHOLOGICAL
☐ I DENY ANY **PSYCHOLOGICAL** ISSUE
☐ ANHEDONIA (LACK OF JOY) ☐ ANXIETY ☐ BEHAVIORAL CHANGE(S) ☐ CONFUSION ☐ DEPRESSION ☐ MEMORY LOSS
☐ APPETITE CHANGES ☐ BIPOLAR DISORDER ☐ CONVULSIONS ☐ INSOMNIA ☐ MOOD CHANGE(S)

ALLERGY
☐ I DENY ANY **ALLERGY** ISSUE(S)
☐ ANAPHYLAXIS (HISTORY OF SNEEZING) ☐ FOOD INTOLERANCE ☐ ITCHING ☐ SNEEZING ☐ NASAL CONGESTION

HEMATOLOGY
☐ I DENY ANY **HEMATOLOGY** ISSUE(S)
☐ ANEMIA ☐ BLOOD CLOTTING ☐ BRUISES EASILY ☐ LYMPH NODE SWELLING
☐ BLEEDING ☐ BLOOD TRANSFUSION ☐ FATIGUE

PAST HEALTH HISTORY—Please fill out carefully as these problems can affect your overall course of care.

CHILDHOOD ILLNESS
☐ I DENY ANY CHILDHOOD ILLNESS(ES)
☐ ADD ☐ BED WETTING ☐ DIABETES ☐ FOOD ALLERGIES ☐ MEASLES ☐ SEIZURE DISORDER
☐ ALLERGIES ☐ CEREBRAL ☐ EAR INFECTIONS ☐ HEADACHES ☐ MUMPS ☐ SICKLE CELL ANEMIA
☐ ASTHMA ☐ CHICKEN POX ☐ FETAL DRUG EXPOSURE ☐ HEPATITIS ☐ RASH ☐ SPINA BIFIDA
☐ ECZEMA ☐ DEPRESSION ☐ HIV ☐ SCOLIOSIS ☐ OTHER

ADULT ILLNESS
☐ I DENY ANY ADULT ILLNESS(ES)
☐ ALZHEIMER'S ☐ CVA ☐ FIBROMYALGIA ☐ LUPUS (DISCOID) ☐ SEIZURE DISORDER
☐ ANEMIA ☐ CYSTIC KIDNEY DISEASE ☐ HEART DISEASE ☐ LUPUS (SYSTEMIC) ☐ SHINGLES
☐ ARTHRITIS ☐ DEPRESSION ☐ HEPATITIS ☐ MULTIPLE SCLEROSIS ☐ STD'S (UNSPECIFIED)
☐ ASTHMA ☐ DIABETES ☐ HIV ☐ PARKINSON'S DIS- ☐ SUICIDE ATTEMPT(S)
☐ CANCER ☐ DIABETES (NON ☐ HYPERTENSION ☐ PLEURISY ☐ THYROID PROBLEMS
☐ CHICKEN POX ☐ EAR INFECTIONS ☐ INFLUENZA PNEUMONIA ☐ PNEUMONIA ☐ VERTIGO
☐ CROHN'S/ COLITIS ☐ EMPHYSEMA ☐ LIVER DISEASE ☐ PSYCHIATRIC PROBLEMS ☐ PAST HISTORY OF SIMILAR SYMPTOMS TO YOUR CURRENT CONDITION
☐ CRPS (RSD) ☐ EYE PROBLEMS ☐ LUNG DISEASE ☐ SCOLIOSIS

PAST HEALTH HISTORY (CON'T)

SURGERIES: ☐ I DENY ANY SURGERY (IES)

☐ ANGIOPLASTY ☐ APPENDECTOMY ☐ C-SECTION ☐ CARDIAC CATHETERIZATION ☐ CARPAL TUNNEL REPAIR
☐ COSMETIC ☐ DENTAL SURGERY ☐ D & C ☐ CORONARY ARTERY BYPASS ☐ GALL BLADDER
☐ HEMORRHOIDECTOMY ☐ HERNIA REPAIR ☐ HYSTERECTOMY ☐ JOINT RECONSTRUCTION ☐ JOINT REPLACEMENT
☐ LAMINECTOMY ☐ MASTECTOMY ☐ PACEMAKER INSERTION ☐ ROTATOR CUFF ☐ SPINAL FUSION
☐ TONSILLECTOMY ☐ OTHER (PLEASE BE SPECIFIC) ____________ ____________ ____________

OB/GYN: ☐ I DENY ANY OB/GYN ISSUE(S):

☐ I HAVE NEVER BEEN PREGNANT ☐ I HAVE BEEN PREGNANT IN THE PAST ☐ I AM CURRENTLY PREGNANT

MENSTRUAL HISTORY: AGE OF ONSET ________
☐ MY MENSES IS REGULAR ☐ MY MENSES IS IRREGULAR ☐ I AM CURRENTLY IN MENOPAUSE DATE OF LAST MENSES ___/___/___

INJURIES: ☐ I DENY ANY INJURY (IES):

☐ BACK INJURY ☐ BROKEN BONES ☐ SEVERE FALL ☐ FRACTURE ☐ DISABILITY ☐ HEAD INJURY ☐ INDUSTRIAL ACCIDENT ☐ JOINT INJURY ☐ SEVERE LACERATION ☐ MOTOR VEHICLE ACCIDENT ☐ MILD/MODERATE SOFT TISSUE INJURY ☐ SEVERE SOFT TISSUE INJURY

IMMUNIZATIONS: ☐ I DENY ANY IMMUNIZATION(S)

☐ DTaP (DIPHTHERIA, TETANUS & PERTUSSIS ☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ HEPATITIS C ☐ INFLUENZA ☐ IPV (POLIO) ☐ MMR (MEASLES, MUMPS, RUBELLA) ☐ PNEUMOCOCCAL ☐ PPD (MANTOUX TEST –TB) ☐ SMALL POX ☐ TB ☐ VARIVAX (CHICKEN POX) ☐ WHOOPING COUGH (PERTUSSIS)

NON-DRUG ALLERGIES: ☐ I DENY ANY NON-DRUG ALLERGIES

☐ ANIMALS ☐ DAIRY ☐ EGGS ☐ FOOD COLORING ☐ MOLD ☐ SHELL FISH ☐ WHEAT ☐ BEES ☐ POLLEN

PREVIOUS TREATMENT

PREVIOUS CHIROPRACTIC CARE ? ☐ YES IF YES, WHO? (NAME) ☐ NO

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ☐ YES IF YES, WHO? (NAME) ☐ NO **LOCATION OF OFFICE:** **TYPE OF TREATMENT:**

WERE YOU SATISFIED WITH THE RESULTS OF YOUR TREATMENT? ☐ YES EXPLAIN: ☐ NO

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS? ☐ YES IF YES, PLEASE MARK ☐ NO OR LIST (BE SPECIFIC) ☐ ALLERGY MEDICATION ☐ ANTI-DEPRESSANTS ☐ BLOOD PRESSURE MEDS. ☐ INSULIN ☐ MUSCLE RELAXERS ☐ NERVE PILLS ☐ PAIN KILLERS ☐ OTHER:

DO YOU WEAR ANY OF THE FOLLOWING? ☐ HEAL LIFTS ☐ INNERSOLES ☐ ARCH SUPPORTS ☐ ORTHOTICS

PLEASE LIST ANY OTHER CONDITIONS YOU FEEL WE SHOULD KNOW ABOUT—EVEN IF UNRELATED:

SOCIAL HISTORY

ALCOHOL: ☐ NEVER ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ SOCIAL CONSUMPTION ONLY ☐ BEER ☐ WINE O.Z'S #GLASSES ☐ LIQUOR

DIET MARK ALL THAT APPLY ☐ HIGH FAT ☐ HIGH FIBER ☐ HIGH PROTEIN ☐ HIGH SALT ☐ LOW CALORIE ☐ LOW CARB ☐ LOW FIBER ☐ LOW SALT ☐ LOW SUGAR

DRUGS: ☐ DENY ALL ILLEGAL DRUG USE ☐ DENY USE OF IV DRUGS ☐ HAVE NOT USED DRUGS SINCE ☐ HAVE USED DRUGS FOR ______

TOBACCO: ☐ DENY TOBACCO USE ☐ LIVE W/A SMOKER ☐ QUIT SMOKING # PER: _____ ☐ DAY ☐ MONTH ☐ WEEK ☐ # CHEW __________

FAMILY HISTORY

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

Over 70% of our patients allow us to examine their family members for FREE within 2 weeks of starting care. Would you like to take advantage of this?

☐ **Yes** ☐ No thank you

PLEASE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Align Health will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Align Health will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also clearly understand that if I do not follow Align Health's specific recommendations, that I will not receive full benefit from these programs, and that if I terminate my care prematurely, all fees inquired will be due and payable at that time. I hereby authorize Dr. Tellier to treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I also agree that I am responsible for all bills incurred at this office. I acknowledge that I have received the Chiropractic Clinics Notice of Privacy Practices for protected health information.

GUARDIAN OR SPOUSE'S SIGNATURE OF AUTHORIZING CARE: (SIGNATURE INDICATES CONSENT TO TREAT) **DATE:**

PATIENT (PRINT NAME): **PATIENT SIGNATURE** X **DATE:**