

General Information

Name _____ Today's Date ___/___/___
Address _____ City _____
State ___ Zip Code _____ Home # () _____ Work # () _____
Mobile # () _____ Birth Date ___/___/___ Male _____ Female _____
E-Mail _____ Social Security # _____ - _____ - _____
Single _____ Married _____ Divorced _____ Widowed _____ Name of Spouse _____
Employee Status: Emp. _____ F/T Student _____ P/T Student _____ Other _____
Occupation _____ Employer _____
Address _____ City _____ State _____ Zip Code _____
Who may we thank for referring you to our office? _____

Your Health Profile

Main reason for consulting our office today? _____

Check any symptom(s) you may have: _____ Pain _____ Numbness _____ Aches _____ Weakness

How long have you been living with the symptoms(s)? _____

Check status of symptom(s): _____ Worse _____ Improving _____ Intermittent _____ Constant _____ Can't say

Are symptom(s) affected by: _____ Sitting _____ Standing _____ Walking _____ Bending _____ Lying Down

_____ Weather _____ Other, please explain _____

Do symptom(s) interfere with: _____ Work _____ Sleep _____ Play _____ Day-to-day activities

If you see any other Doctor(s) please provide information:

Other Doctor: _____ Location: _____ Phone: _____

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On a scale from 1-10 with 10 being the best you have ever felt and 1 being the worst you have ever felt, where do you see yourself now (circle one):

1 2 3 4 5 6 7 8 9 10



Clarifying Your Health Objectives

In addition to your visit today, what additional health objectives do you have for yourself in the next 5 years?

Are you as healthy (or healthier) today as you were 5 years ago? [] Yes [] No [] Don't Know

If yes, what action steps have you taken? _____

Are you seeking care for: _____ Health Wellness/Optimization _____ Health Problem _____ Both

What would you like to gain from care? _____

Are there any other health concerns you would like us to know about? _____

In your own words, what do chiropractors do? _____

X-RAY RELEASE: This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation if applicable. I have been advised that x-ray can be hazardous to an unborn child.

I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible and I assume responsibility for all charges incurred to me.

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge.

Signed _____ Date ____/____/____

In the case the above signature is a minor, I authorize Align Wellness Center to provide the appropriate care as needed.

Signed _____ Date ____/____/____