



www.**AligntheSpine**Chicago.com

NAME: _____

ADDRESS: _____ City _____ Zip _____

PHONE#(HOME) _____ (CELL) _____ (WORK) _____

EMAIL ADDRESS _____

OCCUPATION _____ EMPLOYER _____

MARITAL STATUS _____ DATE OF BIRTH _____

EMERGENCY CONTACT _____ PHONE# _____

HOW DID YOU HEAR ABOUT OUR OFFICE _____

HAVE YOU BEEN TREATED BY A CHIROPRACTOR BEFORE? _____

INSURANCE INFORMATION

DO YOU HAVE MEDICAL INSURANCE? _____

IF YES, PLEASE PRESENT INSURANCE CARD TO BE PHOTOCOPIED

NAME OF MEDICAL INSURANCE _____

IS THIS AN HMO POLICY? _____

IF KNOWN, DEDUCTIBLE AMOUNT _____ AMOUNT MET FOR YEAR _____

DO YOU HAVE A FLEX SPENDING HEALTH ACCOUNT? _____

IF SO, AMOUNT? _____

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN AND GRANT THE BENEFITS THAT I AM ELIGIBLE TO RECEIVE FOR PROFESSIONAL SERVICES RENDERED IN THIS OFFICE TO PERFORMANCE CHIROPRACTIC CENTER. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIMS FOR PAYMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THOSE CHARGES NOT PAID BY MY INSURANCE COMPANY.

PATIENT'S SIGNATURE _____ DATE _____

CONFIDENTIAL HEALTH HISTORY

CURRENT CONDITION(S):

Circle the area(s) on the figure which is(are) causing you pain.

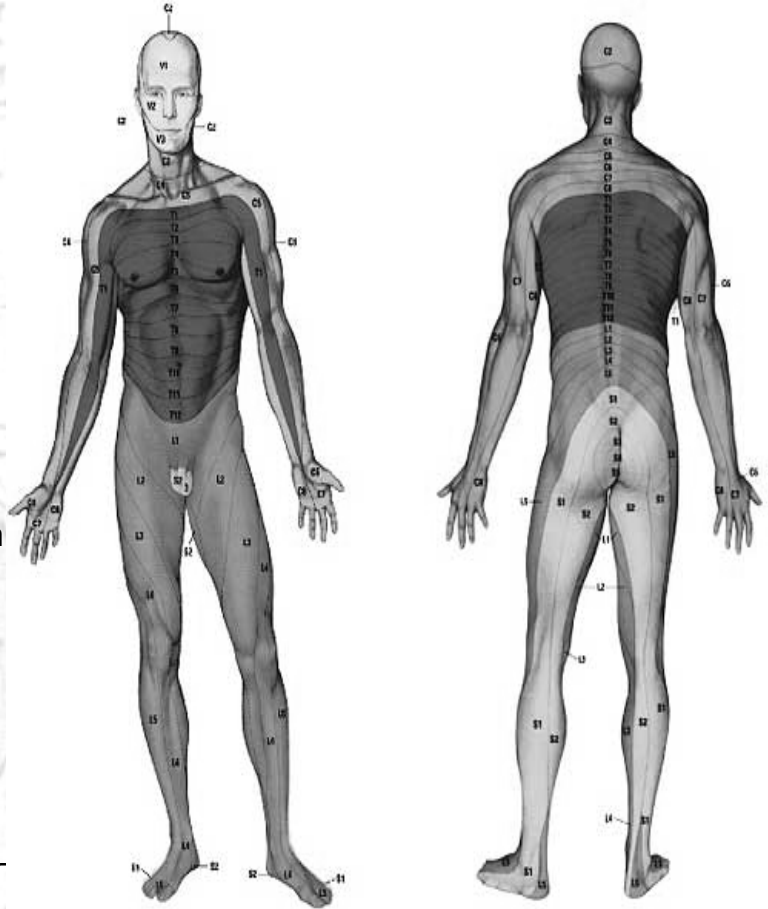
Check all that apply:

- = STABBING
- = NUMBNESS
- = BURNING
- = ACHE
- = PINS & NEEDLES
- = SHOOTING
- = OTHER

Have you experienced this problem in the past?

- = YES
 - = 1-4 episodes
 - = 5-9 episodes
 - = >10 episodes
- = NO

Briefly describe how this injury began:



Circle the number which most accurately describes the severity of your pain **at this moment**
 (no pain) 1 2 3 4 (moderate pain) 5 6 7 8 9 10 (severe pain)

Circle the number which most accurately describes the severity of your pain **at its worst**
 (no pain) 1 2 3 4 (moderate pain) 5 6 7 8 9 10 (severe pain)

Your symptoms are :
 rapidly worsening slowly worsening staying the same slowly improving rapidly improving

Briefly explain what makes your problem:

Less
Severe _____

More
Severe _____

Health History

List and explain any current medical conditions you are diagnosed with and describe current treatments

List and describe past diseases and/or illnesses you have been treated for

List and describe any medications you are currently taking, and indicate the length of time you have been taking the medication

List and describe your family's health history ex. High blood pressure, stroke, Alzheimer's, high cholesterol, heart attack, etc...

Your last medical examination was when? _____ Do you smoke? _____
How many per day? _____

Your activity level throughout the day is ___ low ___ mod ___ high

You participate in exercise and/or stretching:

___ Never ___ Rarely (1-2 x week) ___ Often (3-5 x week) ___ Always (6-7 x week)

Please check any of the following in which you have experienced symptoms within the past 12 months:

___ Headaches ___ Dizziness ___ Blurred Vision ___ Heart Palpitations
___ Indigestion ___ Constipation ___ Unusual Bleeding ___ Seizures ___ Weight Loss
___ Weight Gain ___ Night Sweats ___ Tremors ___ Neck Pain ___ Shoulder Pain
___ Elbow Pain ___ Wrist Pain ___ Finger Pain ___ Pain Between Shoulder Blades

Mid Back Pain Low Back Pain Hip Pain Leg Pain Knee Pain
 Ankle Pain Foot Pain Toe Pain



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Your concerns and goals are very important to the outcome of your treatments. **Please indicate any other pertinent information concerning you and / or your health which was not addressed within this form.**

A faint, light-colored background image of Leonardo da Vinci's Vitruvian Man is visible behind the text. The figure is centered within a circle and a square, with arms and legs extended.

By signing below, you attest to the accuracy to the best of your knowledge that the given information within these forms is complete and truthful, and you give your permission to receive chiropractic treatment.

Signature: _____

Date: _____