Aligned

Patient Information

Name: ____ Sex: ☐ Male ☐ Female
Last First MI

Age: ______ DOB: ___________ SSN# ______ - ______ - ______ Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Latin American ☐ Other

Address: ____ City: ____________________ State: _______ Zip: _________

Email: ____________________________________ Phone: ____________________ (C) ________________ (H) ___________________ (W)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ Other

Occupation: ____ Employer: ____

Emergency Contact: Name: _______________________________ Relationship: _________________________ Phone: __________________

How did you hear about our practice? ____

Accident Information

Is this visit due to an accident?: ☐ Yes ☐ No If yes, what type? ____

Has it been reported? ☐ Yes ☐ No If yes, to whom? ____

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic care carries some risk to treatment; including, but not limited to fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based on the facts known.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Aligned.

Would you like to receive a paper copy of the practices? ☐ Yes ☐ No Initial: _____________ If, no I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_________ I acknowledge that Aligned will leave reminder messages on my answering machine. I acknowledge if I should have a problem or question, I may speak with the Privacy Officer, Dr. Joshua Katz, about my concerns.

_________ I give permission to Aligned to contact my primary care provider, in order to achieve greater results. These lines of communication will only benefit the care and progress during their treatment plan.

SIGNATURE: ____ DATE: _________________

PERSONAL HEALTH HISTORY

Who is your primary care physician? (Doctor and practice) _______________________________Tel#__________________________

Are you currently under drug and/or medical care? ☐ Yes ☐ No if yes, explain: ____

Please list or provide printed copy of any medications/supplements you are currently taking (include dosage and frequency): ________

____

Please list any surgeries and/or hospitalizations you have had (type & date): ____

____

Please list any allergies: ____

Do you exercise: ☐ Yes ☐ No if yes, How often? _______________ What do your work activities mostly involve? ________________

What is your daily/weekly intake of the following: Caffeine ______ cups/day Alcohol ______drinks/week Cigarettes ________ packs/day

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness ☐ Pins/Needles in Arms ☐ Sudden Weight Loss ☐ Light Bothers Eyes ☐ Cancer ☐ Fatigue
☐ Back Pain/Stiffness ☐ Pins/Needles in Legs ☐ Disc issues ☐ Loss of Taste ☐ Cold Feet ☐ Fever
☐ Arm/hand Pain ☐ Nervousness ☐ Loss of Memory ☐ Pour wound healing ☐ Hot Feet ☐ Fainting
☐ Leg/Knee Pain ☐ Sleeping Difficulties ☐ Stenosis ☐ Pinched Nerve ☐ Tension ☐ Allergies
☐ Headaches ☐ Loss of Smell ☐ Heavy feet ☐ Loss of balance ☐ Night pain ☐ Blurred Vision
☐ Dizziness ☐ Carpal Tunnel ☐ Arthritis ☐ Degenerative Disc
☐ Knee Pain ☐ Pain between shoulder blades ☐ Numbness/Tingling in Legs/Feet
☐ Numbness/Tingling in Arms/Hands ☐ Other: ____

Which of the above is the worst? ____

How long have you had it? ____

How often does it occur? ____

What have you done that helps this problem? ____

What activities would you like to do if this was not a problem? ____

Does this cause you to be: ☐ Moody ☐ Irritable ☐ Interrupt sleep ☐ Restricted in your daily activities

Does this affect your work: ☐ Decision Making ☐ Poor Attitude ☐ Decreased Productivity ☐ Unable to work long hours

Does this affect your life: ☐ Lose patience ☐ Restricted activities ☐ Hinders abilities to exercise ☐ Interferes with hobbies

What have you tried to help relieve/get rid of this problem and how much did it help?

☐ Medications: Little, Some, Much ☐ Physical Therapy: Little, Some, Much ☐ Chiropractic: Little, Some, Much
☐ Exercise: Little, Some, Much ☐ Nutrition: Little, Some, Much ☐ Stretching: Little, Some, Much
☐ Other: ____

Please check to indicate if you have ever had any of the following:

☐ Aids/HIV ☐ Cancer ☐ Hepatitis ☐ Osteoporosis ☐ Stroke ☐ Alcoholism ☐ Cataracts
☐ Hernia ☐ Pacemaker ☐ Suicide Attempt ☐ Allergy Shots ☐ Herniated Disc ☐ Anemia ☐ Chicken Pox
☐ Herpes ☐ Tonsillitis ☐ Pinched Nerve ☐ Anorexia ☐ Diabetes ☐ Pneumonia ☐ Tuberculosis
☐ Appendicitis ☐ Emphysema ☐ Kidney Disease ☐ Polio ☐ Arthritis ☐ Epilepsy ☐ Asthma
☐ Fractures ☐ Measles ☐ Prosthesis ☐ Ulcers ☐ Glaucoma ☐ Migraines ☐ Breast Lump
☐ Goiter ☐ Miscarriage ☐ Bronchitis ☐ Gonorrhea ☐ Mononucleosis ☐Bulimia ☐ Gout
☐ Scarlet Fever ☐ Mumps ☐ Heart Disease ☐ Multiple Sclerosis ☐ Chemical Dependency ☐ Rheumatic Fever
☐ Parkinson's Disease ☐ Thyroid Problems ☐ Liver Disease ☐ Tumors/Growths ☐ Psychiatric Care ☐ Bleeding Disorders
☐ Prostate Problems ☐ Typhoid Fever ☐ Venereal Disease ☐ Whooping Cough ☐ Rheumatoid Arthritis ☐ Vaginal Infections
☐ Surgeries Please list:____ Other:_______________________________________

Have any immediate family members have/had: Heart Disease, Diabetes, Stroke, or Cancer If yes, relationship and what?

____

____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: ____ DATE: _____________

Quality of Life Survey

The following information should be filled out based on the condition that you most want help with:
This information allows our healthcare team to better serve you and meet your expectations for care.

1. **How have you taken care of your health in the past?**
   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Exercise
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic
   i. Other (please specify) ______________________________

2. **How did the above methods work out for you?**
   a. Bad results
   b. Some results
   c. Great results
   d. Nothing changed
   e. Did not get worse
   f. Did not work very long
   g. Still trying
   h. Confused

3. **How have others been affected by your health condition?**
   a. No one is affected
   b. Haven't noticed any problem
   c. They tell me to do something
   d. People avoid me

4. **What are you afraid this might be (or beginning) to affect (or will affect)?**
   a. Ability to work
   b. Kids/ grandkids
   c. Future abilities
   d. Marriage/ Relationships
   e. Self-Esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom

5. **Are there health conditions you are concerned this might turn into?**
   a. Family health problems
   b. Heart disease
   c. Cancer
   d. Diabetes
   e. Arthritis
   f. Fibromyalgia
   g. Depression
   h. Chronic Fatigue
   i. Need Surgery

How has your health condition affected your job, relationships, finances, family, or other activities?

What has that cost you? (time, money, happiness, freedom, sleep, promotions, etc)

What are you most concerned with regarding your problem?_

Where do you picture yourself being in the next 1-3 years if this problem is **not** taken care of? Please be specific.

What would be better/different without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

Please bring these forms with you to your appointment. We aim to keep your scheduled appointment time and completing these forms ahead of time helps us serve you best. We look forward to meeting you and helping you along the path to your best health.