Align Chiropractic
1275 Main St 110
Buffalo, NY 14209
716.882.5446

Today's Date: _____/_____/_____

Patient Information:

(Please fill this form out to the best of your ability.)

Patient Name (Last, First, M.I.): _____Nick Name: _____

Birth Date: _____/_____/_____Age: _____Sex: _Male __Female__ Social Security #: _____-_____-_____

Address: _____City: _____State: _____Zip Code: _____

Home Phone: _____Cell/Alternate Phone: _____E-Mail:_____

Employer: _____Work Phone: _____Can We Contact You Here? _Yes _No

Name of Spouse/Partner or Guardian (if underage):_____Birth Date: _____/_____/_____

Emergency Contact: _____Relationship: _____Phone #:_____

Names and Ages of Children: _____

I Chose This Office Because…_____

Insurance Information:

Please allow us to make a copy of your insurance identification card

Name Of Primary Insurance: _____Group/Account #:_____Policy #:_____

Policy Holder's Name: _____Birth Date: _____/_____/_____Social Security #: _____-_____-_____

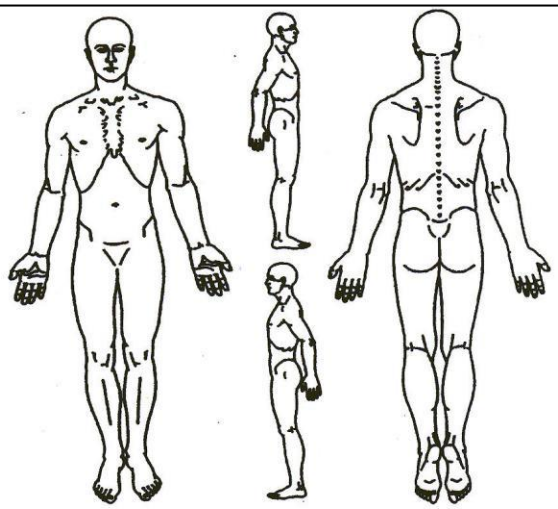
Patient's Relationship to Policy Holder: _Self _Spouse _Child _Other_____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize the above listed clinic or insurance company to release any information required to process my claims.

Signature (Guardian if underage):_____**Date:** _____

Align
Family, Pediatric & Pregnancy Chiropractic

Please draw in where you are experiencing your problem



Patient Health Questionnaire

1. Symptoms began on: _____Height: _____Weight: _____

2. Briefly describe your symptoms: _____

_____

_____

3. How did your symptoms start? _____

_____

4. Average pain intensity:

a. Last 24 hours: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

b. Past week: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

5. How often do you experience your symptoms?

1 – Constant (76-100% of time) 2 – Frequent (51-75% of time) 3 – Occasional (26-50% of time) 4 – Intermittent (0-25% of time)

6. How much have your symptoms interfered with your daily activities? (Including both work outside the home and housework)

1 – Not at all 2 – A little bit 3 – Moderately 4 – Quite a bit 5 – Extremely

7. How are your symptoms changing?

1 – Getting Better 2 – Not Changing 3 – Getting Worse

8. Have you seen anyone else for your symptoms? 1 – Yes 2 – No

If "yes", who and what treatment? _____

9. In general, how is your overall health right now?

1 – Excellent 2 – Very Good 3 – Good 4 – Fair 5 – Poor

10. Past/Present Health History (*Please indicate any other health conditions past or present in the area below.*)

_ Headaches	_ Depression	_ Dizziness	_ Digestion Problems
_ Stroke	_ Joint Pain	_ Cancer/Tumor	_ Frequent Urination
_ Asthma	_ High Blood Pressure	_ Bladder/ Bowel Change	_ Birth Control Pills
_ Back Pain	_ General Fatigue	_ Diabetes	*(Female Only)*
_ Heart Attack	_ Arthritis	_ Smoking/Tobacco Use	_ Stomach Pain
_ Shortness of Breath	_ Sinus Problems/Allergies	_ Excessive Thirst	_ Prostate Problems
_ Neck Pain	_ Weight Loss/Gain	_ Drug/Alcohol	_ Pregnancy *(Female*
_ Heart Disease	_ Kidney Disorders	Dependence	*Only)*

_Other: _____

11. List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

12. List all surgical procedures and hospitalizations:

_____

13. If pregnant: estimated due date and name of provider:_____

Patient Signature: _____**Date:** _____