ALIGN FAMILY
CHIROPRACTIC AND WELLNESS CENTRE

YOUR PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Gender M / F / X

Address:_____ City: _____ Postal Code: _____

Home Telephone #: _____ Cell #: _____ Work#_____

Email: _____

Is it okay to send you appointment reminders via email? ☐Yes ☐No

Is it okay to contact you at work? ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Divorced

Number of Children:_____

Occupation: _____Name of Business: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Medical Doctor: _____ Phone: _____

Last Physical Exam: _____

Have you had previous Chiropractic care? ☐Yes ☐No

Where? _____When? _____

How did you hear about us? _____

Reason for your visit? ☐Health Optimization ☐Injury ☐Complaint ☐Other

Health Information

What brings you into our office today? _____

Past Health History

Please check if you presently have or have had any of the following conditions in the past:

☐Blurring of Vision	☐Bronchitis	☐Diarrhea	☐Insomnia
☐Stroke	☐Asthma	☐Stomach	☐Ulcer
☐Tendonitis	☐Dizziness	☐Respiratory condition	☐Heart Burn
☐Urinary Frequency	☐High Blood Pressure	☐Chest Pains	☐Headaches
☐Lower Back Pain	☐Heart Disease	☐Diabetes	☐Allergies
☐Numbness or Tingling in Arms or Legs		☐Aneurysm	☐Hiatus Hernia
☐Sinusitis	☐Varicose Veins	☐Constipation	☐Ringing In Ears
☐Menstrual Problems	☐Osteoporosis	☐Anxiety	☐Loss of Appetite
☐Unexplained Weight Loss/Gain		☐Changes to bowel or bladder habits	
☐Poor Coordination	☐Poor Balance	☐Frequent Colds	☐Ear Infections

Other health problems? _____

_____

_____

Please check off any surgeries you have had and record the year:

☐ Appendectomy_____ ☐ Tonsillectomy_____ ☐ Broken Bones_____

☐ Gallbladder_____ ☐ Hernia_____ ☐ Spinal Surgery_____

☐ C-Section_____ ☐Other_____

Have you recently had dental work done? _____

List of medications you now take: _____

_____

Date of last dose of antibiotics: _____

List of supplements you take (including brand if known): _____

_____

List and describe any auto accidents or other accidents/injuries: _____

_____

_____

List and describe any childhood injuries/accidents/hospitalizations/illnesses:

_____

Have you been diagnosed with any concussions? ☐Yes ☐No

If yes, list the date of your last concussion: _____

FEMALE PATIENTS ONLY

Are you pregnant? ☐Yes ☐No ☐ Not sure If yes, how many weeks? _____

Are you breastfeeding? ☐Yes ☐No

Are you presently trying to conceive? ☐ Yes ☐ No

Are you taking birth control? ☐Yes ☐No

What was the 1st day of your last period? _____

Do you have irregular or painful periods? ☐Yes ☐No

Have you reached menopause? ☐Yes ☐No

Any pelvic conditions/surgeries (such as PCOS, endometriosis, fibroids, hysterectomy): ☐Yes ☐No

If Yes, please explain_____

Are you on HRT? ☐Yes ☐No

LIFESTYLE

Rate your diet: ☐Poor ☐Fair ☐Medium ☐Good ☐Excellent

Do you follow a special diet? (gluten free, vegan, Paleo, dairy free, Etc.?)_____

Rate your sleep habits: ☐Poor ☐Fair ☐Medium ☐Good ☐Excellent

How often do you exercise: ☐Daily ☐3-5 Days/Week ☐1-2 Days/Week ☐Infrequent

Average length of workout ☐>30 minutes ☐30-60 Minutes ☐ <60 minutes

Types of exercise done: ☐Cardio ☐Resistance ☐Intervals ☐Yoga

How well do you cope with stress? ☐Poorly ☐Ok ☐Well

Rate your energy level: ☐Exhausted ☐Low ☐Good ☐Excellent

Do you use tobacco? ☐Yes ☐No

If Yes, Packs/day_____

Year Quit_____

Do you drink coffee? ☐Yes ☐No

If yes, how many cups/day? _____

Do you drink pop? ☐Yes ☐No

If yes, how many cans/day? _____

Is there anything else you feel we should know about? _____

_____