Align Chiropractic
504 Elmwood Ave
Buffalo, NY 14222
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…_____

Billing Information:

Person Responsible For Bill: _____Birth Date: _____/_____/_____Social Security #:_____-_____-_____

Address (If Different):_____City: _____State: _____Zip Code: _____ Home

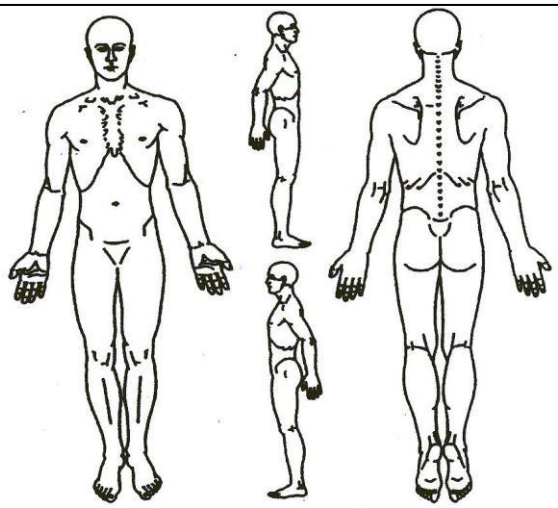
Phone #: _____Is This Person Here? _Yes _No Relationship: _____

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: _____

Patient Health Questionnaire

Please draw in where you are experiencing your problem



1. Symptoms began on: _____Height: _____Weight: _____

2. Briefly describe your symptoms: _____

_____

_____

Circle: sharp dull throbbing burning achy numb tingling other_____

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?

Circle: Constant (76-100% of time) Frequent (51-75% of time) Occasional (26-50% of time) Intermittent (0-25% of time)

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

Circle: Not at all A little bit Moderately Quite a bit Extremely

7. How are your symptoms changing?

Circle: Getting Better Not Changing Getting Worse

8. Have you seen anyone else for your symptoms? ____ Yes ____ No

If "yes", who and what treatment? _____

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

Circle: Excellent Very Good Good Fair 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	_ Stomach Pain
_ Heart Attack	_ Arthritis	_ Smoking/Tobacco Use	_ Prostate Problems
_ Shortness of Breath	_ Sinus Problems/Allergies	_ Excessive Thirst	_ Pregnancy
_ Neck Pain	_ Weight Loss/Gain	_ Drug/Alcohol Dependence	_Other_____
_ Heart Disease	_ Kidney Disorders		

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

_____

12. List all surgical procedures and hospitalizations:

_____

I verify that the information submitted on this form is true and accurate to the best of my knowledge:

Signature: _____ **Date:** _____