INTAKE FORM & HISTORY

Patient Information

First Name:_____

Last Name:_____

Home Address:_____

_____

Country:_____

Postal Code:_____

Home Number:_____

Mobile Number:_____

Email:_____

Age:_____ Date of Birth:_____

Occupation:_____

Hobbies/Interests:_____

In Case of Emergency, contact:

Name:_____

Relationship:_____

Contact Number:_____

How did you end up at Align 4 Life?

- □ Referred by family or friend
- □ Referred by Healthcare Professional
- □ Drive by/Walk in
- □ Website
- □ Facebook/Instagram (Please circle which)
- □ Talk
- □ Spinal Screening
- □ Website

How can we help you?

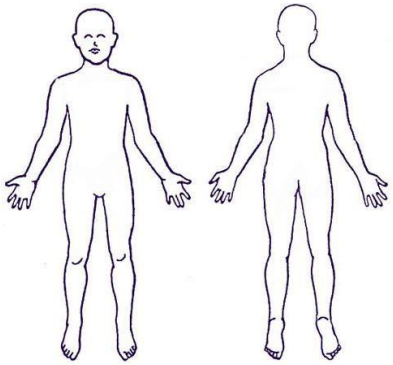
1) What brings you in today?_____

_____

2) If you are already experiencing a symptom, what is it? _____

3) How bad is it? How intense are your symptoms? (circle)

4) Please circle areas on the diagram where you have pain or symptoms:



5) What does it feel like?

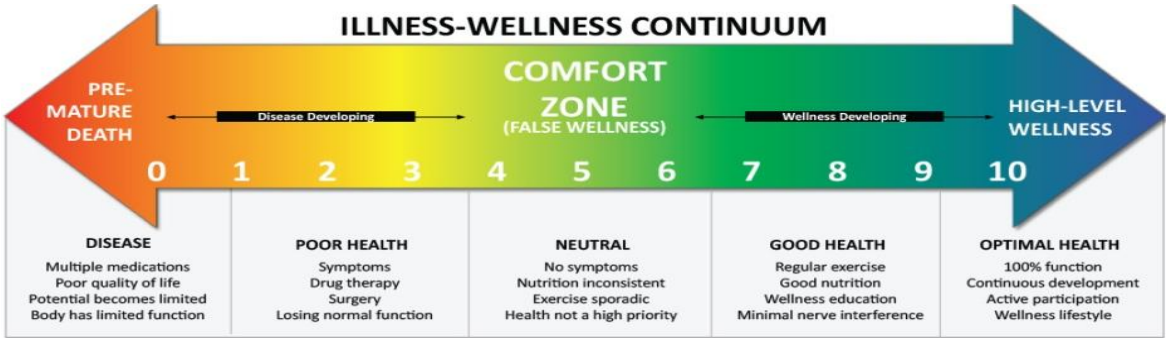
- o Numbness
- o Tingling
- o Stiffness
- o Dull
- o Aching
- o Cramping
- o Nagging
- o Sharp
- o Shooting
- o Burning
- o Throbbing
- o Stabbing
- o Swelling
- o Other: _____

6) How is this symptom/condition interfering with your life? (Check box below where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	□	□	□	□	Energy	□	□	□	□
Exercise	□	□	□	□	Attitude	□	□	□	□
Recreation	□	□	□	□	Patience	□	□	□	□
Relationships	□	□	□	□	Productivity	□	□	□	□
Sleep	□	□	□	□	Creativity	□	□	□	□
Self-Care	□	□	□	□	Other_____	□	□	□	□

7) Do you have any history of trauma or surgery (List)?_____

Patient Wellness Assessment



7) On the arrow diagram above:

- What number do you think represents your health today? _____ - In what direction is your health currently headed?_____

8) What are your health goals?

A) Immediate_____

B) Short Term_____

C) Long Term_____

Health and Illness History

9) Please check the box beside any condition that you have.

- □ Poor Attention
- □ Impulsive
- □ Easily Distracted
- □ Disorganised
- □ Depressed
- □ Lacking Motivation
- □ Poor Concentration
- □ Constipation
- □ Low Pain Threshold
- □ Difficulty Walking
- □ Worry
- □ Irritable
- □ Low Energy

- □ Migraines
- □ Headaches
- □ Seizures
- □ Sleepwalking
- □ Hot Flushes
- □ PMS
- □ Food Sensitivities
- □ Bedwetting
- □ Eating Disorders
- □ Bipolar Disorder
- □ Mood Swings
- □ Panic Attacks

- □ Cold Hands
- □ Cold Feet
- □ Tight Muscles
- □ Teeth Grinding
- □ Anxiety
- □ Heart Palpitations
- □ Restless Sleep
- □ Poor Immune System
- □ Poor Expression of Emotion
- □ Racing Mind
- □ High Blood Pressure
- □ Accelerated Aging
- □ Irritable Bowel

- □ Cancer
- □ Rheumatoid Arthritis
- □ Chronic Fatigue Syndrome
- □ Diabetes
- □ Multiple Sclerosis
- □ Depression
- □ Fibromyalgia
- □ ALS
- □ Epstein-Barr Syndrome

Children and Pregnancy

-Are you currently pregnant? Yes / No - When are you due? _____ - How many children do you have? _____

-Number of past pregnancies? _____ - Childrens ages? _____

-Health concerns regarding this pregnacy?_____ - Childrens health concerns? _____

Allergies, Medications & Supplements

Allergies (List): _____ Medications (List): _____ Supplements (List): _____

_____ _____ _____

_____ _____ _____

- □ I agree to a professional and complete chiropractic examination.
- □ I understand that Align 4 Life will hold and use the information provided on this form for the duration of my care (and for 8 years afterwards as required by law).
- □ I consent/ do not consent(please tick appropriate) to Align 4 Life sending emails related to my care, presentations or educational information, on the basis that my details will not be shared outside Align 4 Life for marketing purposes.
- □ I consent to Align 4 Life to sending me my detailed Report Of Findings (including x-rays) via email.

Name:_____Date: _____ Signature:_____