NEW PRACTICE MEMBER FORM

Welcome to our office! Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you!

Name ________________________________ Birthdate __________Age _____ Date ___________

Address ______________________City _________________State __________Zip ___________

Home Phone _______________Cell Phone ________________Work Phone __________________

Email _________________________________

Would you like to receive email or text reminders (circle one): E-mail Text Phone Carrier: ___________

SSN# ________________ Occupation____________________________ Marital Status: M S W D

Spouse/Partner Name____________________ Children's Names & Ages: ____________________

____

Whom may we thank for referring you?____

Have you been to a chiropractor before? □ Yes □ No If so, who?________________ When?__________

HEALTH INFORMATION:

What are your major complaints? ____

How long have you had this condition? ____

Describe how this condition occurred: ____

What activities aggravate your condition? ____

What gives you relief? ____

Type of Pain: □ Sharp □Dull □ Ache □ Burn □ Throb □ Spasm □ Numb □ Tingling □ Shooting

Does the Pain Radiate into your: □ Arm □ Leg □ Does not radiate

Is this condition getting worse? Yes No On a scale 1 to 10 with 10 being the worst, rate your pain: _____

How often do you experience these symptoms?: 100% 75% 50% 25% 10% Only with Activity

Is this condition interfering with your: □ Work □ Sleep □ Daily routine □ Other _____________________

List all other health problems: ____

Medications you now take: □ None □ Nerve pills □ Pain killers □ Muscle relaxers □ Blood thinners □ Insulin □ Anti-depressants □ Blood pressure □ Other ____

Names of medicines: ____

Medication allergies: ____

HEALTH HISTORY:

List surgical operations & years: ____

Have you ever been in an auto accident? □ Yes □ No Dates: ___________________________________

Describe: ____

Have you had any other personal injury or accident? □ Yes □ No Dates: _________________________

Describe: ____

Head injuries? □ Yes □ No Describe: ____

Broken bones? □ Yes □ No Describe: ____

Are you pregnant? □ Yes □ No If pregnant, Due date: ___________________________

Name of OBGYN or Midwife: ____

Where will you be birthing your baby? □ Hospital □ Home □ Birthing Center □ Other______________

WELLNESS INFORMATION:

Smoking: □ Yes □ No ______per day

Former smoker: □ Yes □ No

Caffeine: □ Yes □ No ______per day

Exercise: □ Yes □ No ______per week

Healthy diet: □ Poor □ Good □ Excellent

Quality sleep: __________hours per night

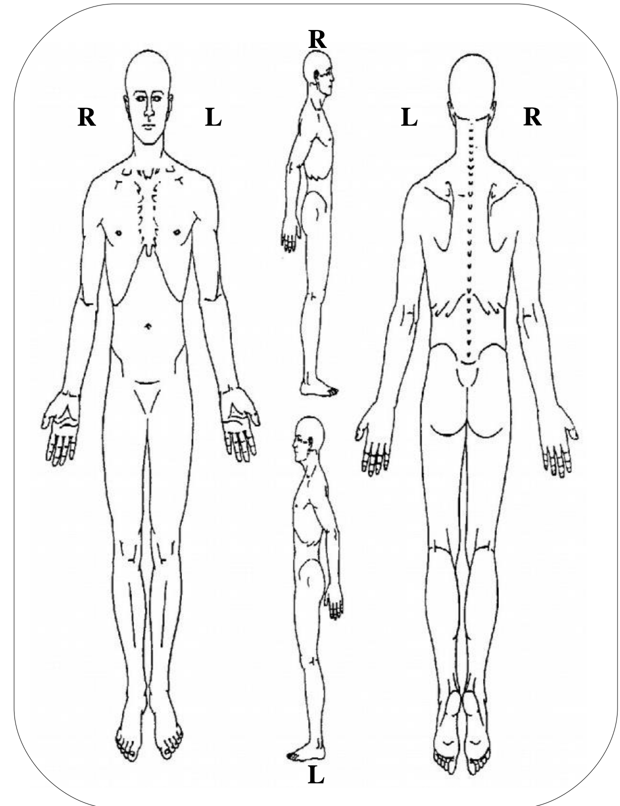
Daily stress: □ Low □ Moderate □ High

Height: ____________Weight: ___________

Have you ever suffered from: (circle Yes or No)

Acid Reflux	Yes No
Arthritis	Yes No
Asthma	Yes No
Backaches	Yes No
Cancer	Yes No
Depression	Yes No
Diabetes	Yes No
Digestive Disorders	Yes No
Dizziness	Yes No
Fatigue	Yes No
Fibromyalgia	Yes No
Headaches	Yes No
Heart Trouble	Yes No
Herniated Disc	Yes No
High Blood Pressure	Yes No
Insomnia	Yes No
Loss of Range of Motion	Yes No
Muscle Spasms	Yes No
Neck Pain	Yes No
Nervousness	Yes No
Neuritis	Yes No
Numbness or Tingling	Yes No
Sciatica	Yes No
Scoliosis	Yes No
Sinus Trouble	Yes No
Stroke	Yes No
TMJ Dysfunction	Yes No

Please mark your areas of pain on the figures below:



Family Health Information:

Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health.

Family Member Name	Relation	Past & Present Health Problems

Practice Member Signature: ______________________________________ Date ____________

If member is a minor, Parent/Guardian Signature:________________________ Date ____________

Aligned Family Chiropractic 2477 Shoreland Avenue, Toledo, Ohio 43611 **Phone** (419) 729-1619

Insurance Information:

Do you have health insurance? □ Yes □ No
Name of Insurance Company ________________________
Contract/ID # ___________________________________
Group # _______________________________________
Insured's Name __________________________________
Relationship to Insured ____________________________
Insured's Birthdate ________________________________
Insured's Social Security # __________________________

Do you have supplemental insurance? □ Yes □ No
Name of Insurance Company ________________________
Contract/ID # ___________________________________
Group # _______________________________________
Insured's Name __________________________________
Relationship to Insured ____________________________
Insured's Birthdate ________________________________
Insured's Social Security # __________________________

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of chiropractic care, and I give authority to these procedures to be performed.

I understand that I am financially responsible for all charges whether or not paid by insurance. I, the undersigned certify that if I (or my dependent) have insurance coverage, all insurance benefits are directly assigned to Dr. Lajiness. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Office Policies

1. If you are unable to keep a scheduled appointment, kindly give 24 hours notification.

2. We understand that unexpected events occur that will cause you to miss an appointment without notification. After the 3rd occurrence you will be charged $20 for any missed appointment.

3. Payments are due at the time the service(s) is rendered. This office may make financial arrangements on an individual basis and will remain confidential. Any such plan or arrangement will be discussed in private.

4. This office accepts all major credit cards, cash, and personal checks.

5. I consent for my picture and/or my child(ren)'s picture to be taken while in the office. Pictures will only be used in this office and on company website(s). If names are displayed, only the first name and first initial of the last name will be used.

I have read and understand the Office Policy and agree to abide by these terms.

Practice Member Signature: ____ Date _____________

If member is a minor, Parent/Guardian Signature: ____________________________ Date ___________