NEW PATIENT FORM

Today's Date: _____

Name _____ (/ /) Date of Birth _____ Street Address _____ Unit _____ City _____ State _____ Zip _____

Cell Phone _____ Carrier (for appt reminder texts) _____ Home Phone _____ Email _____

If you prefer not to receive text message appointment reminders, please check here: ☐ Opt-out of text message reminders

Gender (check all that apply) ☐ Man ☐ Woman ☐ Transgender _____ Employer & Occupation

Emergency Contact: _____ Phone: _____

How did you find us and who can we thank for referring you? _____

Have you ever seen a Chiropractor? ☐ Yes ☐ No **Acupuncturist?** ☐ Yes ☐ No **Functional Medicine Provider?** ☐ Yes ☐ No

Would you like to learn about Acupuncture? ☐ Yes ☐ No **Functional Medicine & Clinical Nutrition?** ☐ Yes ☐ No **Chiropractic?** ☐ Yes ☐ No

What are your health goals? (what is important to you, eg "I want to be stronger" or "I want to run a faster race") _____

Patient Symptoms

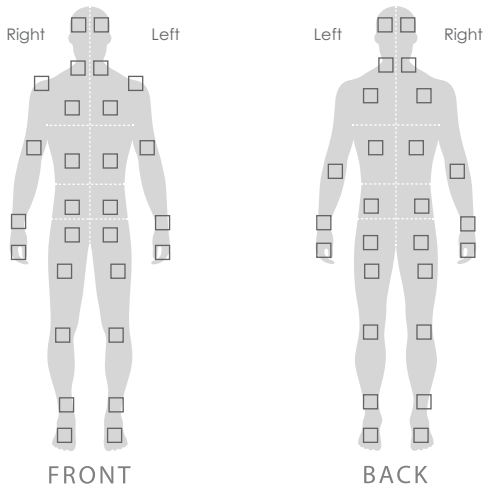
What is the reason for your visit? _____

Using the chart below, please describe any specific health problems that you would like to address, in order of importance.

Describe the problem	Severity (0-10)	Treatment Approaches Tried (if any)	Success Achieved (if any)
Example: Post Nasal Drip	6	*Elimination Diet*	*Moderate*
Example: Neck Pain	9	*Physical Therapy*	*Fair*
a.			
b.			
c.			
d.			
e.			
f.			

Using the body diagram, check off each symptomatic area on the front *and* back of the body.

Office Use:



aligned
MODERN HEALTH

MEDICAL HISTORY

How many hours do you sleep at night? _____ **What time do you go to bed?** _____ **Wake rested?** ☐ **Y** ☐ **N**

What is your energy level? ☐ up and down ☐ low ☐ normal ☐ excess ☐ low after eating ☐ increased after exercise ☐ decreased after exercise

Mental/Emotional? ☐ happy ☐ easily irritable ☐ difficulty making decisions ☐ angry ☐ cry easily ☐ stressed ☐ hurry to do things
☐ depression ☐ anxiety ☐ restlessness ☐ worry ☐ ruminate

List any medications you've taken in the last 3 months, including over the counter medications / supplements.

MEDICATION / VITAMINS / HERBS	DOSAGE	REASON	HOW LONG

Describe any specific diets you follow: _____

Have / Do you...	Yes	No
...been hospitalized in the past 5 years?	☐	☐
...had any surgeries?	☐	☐
...had any emotional / stress disorders?	☐	☐

If yes, please provide a brief explanation:

_____
_____
_____
_____
_____

What are your work duties?

_____

How is most of your day spent?
Standing _____ Sitting _____
Other:

_____

How do you feel about the following areas of your life?

	GREAT	GOOD	FAIR	POOR	BAD	COMMENTS
Significant Other						
Family						
Diet						
Sex						
Self						
Work						
Spirituality						

Office Use:

_____
_____

MEDICAL HISTORY

Do you have or have you previously had any of the following conditions?:

General	Yes	Check if current
Allergies	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Fatigue	☐	☐
Headaches	☐	☐
Loss of sleep	☐	☐
Tremors	☐	☐
Weight change	☐	☐
Seizures	☐	☐
Memory loss	☐	☐

Muscle/Joints		
Arthritis	☐	☐
Bursitis	☐	☐
Foot trouble	☐	☐
Muscle weakness	☐	☐
Low back pain	☐	☐
Mid back pain	☐	☐
Neck pain	☐	☐
Joint pain	☐	☐
Numbness	☐	☐
Tingling	☐	☐

Skin		
Bruise easily	☐	☐
Hives	☐	☐
Rash	☐	☐
Varicose veins	☐	☐
Acne or boils	☐	☐
Itching	☐	☐
Eczema	☐	☐
Infections	☐	☐

Office Use:

Gastrointestinal	Yes	Check if current
Abdominal pain	☐	☐
Bloody stool	☐	☐
Colitis / Crohn's	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heart burn	☐	☐
Appetite change	☐	☐
Hernia	☐	☐
Liver trouble	☐	☐
Nausea	☐	☐
Vomiting	☐	☐

Ear/Eye/Nose/ Throat		
Hearing loss	☐	☐
Ear aches	☐	☐
Ringing in ears	☐	☐
Sinus infection	☐	☐
Sore throat	☐	☐
Vision problems	☐	☐
Frequent colds	☐	☐
Stuffiness	☐	☐
Nose bleeds	☐	☐

Genitourinary		
Bladder infection	☐	☐
Blood in urine	☐	☐
Kidney infection	☐	☐
Kidney stone	☐	☐
Urination:		
Overnight more than twice	☐	☐
>8x in 24 hours	☐	☐
Decreased flow	☐	☐
Painful	☐	☐
Urgency	☐	☐

Cardiovacular	Yes	Check if current
Heart disease	☐	☐
High cholesterol	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Arteriosclerosis	☐	☐
Irregular pulse	☐	☐
Pain over heart	☐	☐
Poor circulation	☐	☐
Swelling of ankles	☐	☐

Respiratory		
Asthma	☐	☐
Chest pain	☐	☐
Chronic cough	☐	☐
Difficulty breathing	☐	☐
Shortness of breath	☐	☐
Spitting up blood	☐	☐

MEDICAL HISTORY

Do you have or have you previously had any of the following conditions?:

Other Conditions	Yes	Check if current
Anemia	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Edema	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
HIV / AIDS	☐	☐
Multiple Sclerosis	☐	☐
Pace maker	☐	☐
Stroke	☐	☐
Osteoporosis	☐	☐
Thyroid disease	☐	☐

Any other conditions?

_____

_____

_____

MEN ONLY	Yes	Check if current
Decrease in libido	☐	☐
Decrease in fullness of erections	☐	☐
Increase in fat distribution around chest and hips	☐	☐
Prostate trouble	☐	☐

WOMEN ONLY	Yes	Check if current
Uterine cysts/fibroids	☐	☐
PCOS	☐	☐
Endometriosis	☐	☐
Vaginal discharge	☐	☐
Hot flashes	☐	☐
Breast lumps	☐	☐
Menopause	☐	☐
Infertility	☐	☐
Irregular periods	☐	☐
Painful periods	☐	☐
Menstrual Flow:		
Heavy	☐	☐
Moderate	☐	☐
Light	☐	☐

Date of last:

Pap _____

Mammogram _____

Thermogram _____

Period _____

WOMEN ONLY	#	Dates/Complications
Pregnancies	____	_____
Live births	____	_____
Miscarriage	____	_____
Abortions	____	_____
Vaginal birth	____	_____
C-Section	____	_____

Office Use:

_____

_____

_____

FAMILY HISTORY

Have any of your blood relatives (mother, father, siblings, grandparents, aunts, uncles, children) had any of the following?:

	Yes	If yes, please list which relative
Alcoholism	☐	
Anemia	☐	
Arteriosclerosis	☐	
Arthritis	☐	
Asthma	☐	
Blood disorders	☐	
Cancer	☐	
Diabetes	☐	*What type:*
		What type:

	Yes	If yes, please list which relative
Emphysema / COPD	☐	
Epilepsy	☐	
Glaucoma	☐	
Heart disease	☐	
High blood pressure	☐	
High cholesterol	☐	
Multiple sclerosis	☐	
Osteoporosis	☐	
Stroke	☐	
Thyroid disease	☐	

Lifestyle

☐ Single ☐ Married ☐ Divorced ☐ Opposite sex partner ☐ Same sex partner ☐ Children Number of children _____

Please describe your habits regarding the following:

	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drug use	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water intake	☐	☐	☐	☐
Sugar intake	☐	☐	☐	☐

Do you have any other health issues or concerns that the doctor should be made aware of?

_____

_____

_____

_____

Other Doctors

Primary Care Physician: _____

Hospital or Associated Group: _____

Address, Phone, and Fax (if known): _____

Did your primary care physician refer you to us: ☐ Yes ☐ No

Please list any other providers you have seen for your condition: _____

May we communicate with your other physicians about your case and treatment? ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

Office Use:

_____

_____

_____

AUTHORIZATIONS AND RELEASES

By initialing and signing below, you agree to the following:

Receipt of Notice of Privacy Practices and Consent For Release and Use of Confidential Information

I have received, understand, and consent to this practice's Notice of Privacy Practices as written that describes how medical information about me may be used and disclosed by Active Wellness, LLC d/b/a Aligned Modern Health and its affiliates and how I can get access to this information. The Notice of Privacy Practices is also posted in the clinic and on Aligned Modern Health's website. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, this practice will provide me a revised Notice of Privacy Practices upon my request. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

(continue to next page)

(continued from previous page)

Financial Obligation and Payment Policies

Initial _____

Responsibility: As a courtesy to our patients who utilize health insurance, we will submit claims for your care directly to your insurance company. You accept full financial responsibility for service rendered by this practice, including any amounts not covered by health insurance, and any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Payment is required for all co-pays, coinsurance, and estimated deductible charges at the time of service unless alternative arrangements are agreed to in advance. After receiving an explanation of benefits and payment by your insurance company, we will refund any credit balances to you.

Initial _____

Automatic Credit Card Charges: We will do our best to collect from your health insurance company. For any amounts that are still outstanding 30 days from the date of service, we will charge your credit card or debit card on file (don't worry, we'll email you first to let you know about the upcoming charge). You authorize us to charge your credit or debit card on file for such balances, and you authorize us to retain credit card, debit card, or other payment source information supplied by you for current and future charges. We will send you a receipt for any charges to your credit or debit card.

Initial _____

Missed Appointments and Late Cancellations:
You will be charged a $40 fee if you miss the appointment or cancel less than 24 hours in advance of the scheduled time.

Agreed and accepted:

Name (print):

_____

Signature: _____ **Date:** _____

EMAIL COMMUNICATION CONSENT

Aligned Modern Health provides patients the opportunity to communicate with their physicians, health care providers, and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
a) General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
b) Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.
2. It is the policy of Aligned Modern Health that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's medical record and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of your medical record. Aligned Modern Health will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail or internet communication.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
a) All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of your medical record. As a part of the protected personal health information, other individuals at Aligned Modern Health such as physicians, nurses, other health care practitioners, insurance coordinators and insurers may have access to e-mail messages contained in your medical record.
b) Aligned Modern Health may forward e-mail messages within the practice as necessary for diagnosis and treatment. Aligned Modern Health will not, however, forward the email outside the practice without the consent of the patient as required by law.
c) Aligned Modern Health will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
d) It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
e) Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
f) Aligned Modern Health cannot guarantee that electronic communications will be private, but we will take reasonable steps to protect the confidentiality of the e-mail or internet communication. Aligned Modern Health is not liable for improper disclosure of confidential information via email or electronic communication.
g) If consent is given for the use of e-mail, it is the responsibility of the patient to inform Aligned Modern Health of any types of information you do not want to be sent by e-mail.
h) It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from Aligned Modern Health to protect confidentiality. Aligned Modern Health is not liable for breaches of confidentiality caused by the patient.
i) Not all messages sent by Aligned Modern Health are encrypted or utilize encryption technology. As such, email messages that are improperly intercepted may be readable by third-parties.
Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Aligned Modern Health.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name (print): _____

Signature: _____ **Date:** _____