Welcome! How did you hear about us? ALIGN CLINIC & ASSOCIATES, P.C.

Please take a few moments to complete this form. Thank You!

Date: _____

Name: _____ _____ Phone #: _____
(First) (Last)

_____ _____ Phone#: _____
(First) (Last)

Address: _____ _____ _____ _____ _____
(Street) (Apt.#) (City) (State) (Zip)

Email Address: _____

How did you find out about us?

❑ Newspaper Ad ❑ Direct Mail Piece ❑ TV ❑ Radio ❑ Family / Friend ❑ Yellow Pages
❑ Search Engine ❑ Magazine ❑ Social Media: Facebook ❑ Our Email
❑ Client (Who can we thank: _____)
❑ Physician: _____ ❑ Attorney: _____
❑ Insurance Co: _____
❑ Other: (Please specify) _____

***** We Absolutely Respect Your Privacy. We will not give out or sell any of your information.**

CASE HISTORY

Name: _____ Age: _____ Date: _____ Case Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone:(H) _____ (C) _____ Fax: _____ E-mail: _____
Date of Birth: _____ Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W # of Children: _____
Occupation: _____ Employer: _____ Telephone (Work): _____ Ext. _____
Insured's Name: _____ Phone: _____ Insured's Date of Birth: _____
Spouse's Name: _____ Spouse's Occupation: _____
Spouse's Employer: _____ Spouse's Telephone (Work): _____
Past Chiropractic Care: ❑ Yes ❑ No When? _____ Doctor's Name: _____
Results: _____ Referred by: _____
Insurance Company: _____ Telephone: _____
Social Security Number: _____ Driver's License Number: _____ State: _____
Spouse's Insurance Company: _____ Telephone: _____
Spouse's Social Security Number: _____ Spouse's Driver's License Number: _____
Emergency Contact: _____ Relationship _____ Contact Number _____

Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the Job ❑ Auto Accident ❑ Personal Injury ❑ Other: ___
Has the accident been reported? ❑ No ❑ Yes ❑ To Employer ❑ Auto Carrier ❑ Other: _____
Are you now or have you ever been disabled? (Service or Work)? ❑ No ❑ Yes When? _____ Why? _____
Have you retained an attorney? ❑ No ❑ Yes Name & Address: _____

Pain Symptoms: (in order of severity)
1. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
2. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
3. _____ Began-(Mo/Yr): _____ Previous Episodes: _____

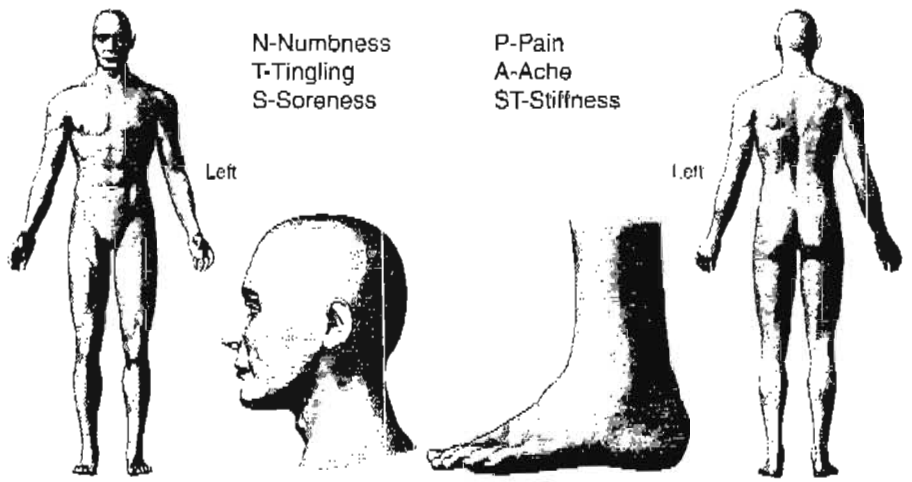
Please mark the intensity of your pain today.
0 - NO PAIN
10 - INTENSE PAIN

Example ___ Neck ___
0 1 2 3 ④ 5 6 7 8 9 10

1. _____
0 1 2 3 4 5 6 7 8 9 10
2. _____
0 1 2 3 4 5 6 7 8 9 10
3. _____
0 1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness P-Pain
T-Tingling A-Ache
S-Soreness ST-Stiffness



DOCTORS USE ONLY

_____
_____
_____
_____

HABITS

❑ Smoking Packs/Day: _____
❑ Drinking Alcohol: _____
❑ Caffeine Cups/Day: _____

EXERCISE

❑ None
❑ Light Activity
❑ Moderate Activity
❑ Active
❑ Very Active
❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑ _____
Father	❑	❑	❑	❑	❑ _____
Brother,# of: ____	❑	❑	❑	❑	❑ _____
Sister,# of: ____	❑	❑	❑	❑	❑ _____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 541	Appendicitis	❑ 280	Anemia	❑ 429.9	Heart Disease	❑ 716	Arthritis
❑ 480	Pneumonia	❑ 055	Measles	❑ 240	Goiter	❑ 345	Epilepsy
❑ 390	Rheumatic Fever	❑ 072	Mumps	❑ 487	Influenza	❑ 319	Mental Disorder
❑ 045	Polio	❑ 052	Chicken Pox	❑ 511	Pleurisy	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

(OVER)

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never ❑ Previously ❑ Presently.

Never	Previously	Presently		GENERAL SYMPTOMS
❑	❑	❑	995.3	Allergy (What)____
❑	❑	❑	490	Bronchitis
❑	❑	❑	780.9	Chills
❑	❑	❑	780.39	Convulsions
❑	❑	❑	780.4	Dizziness
❑	❑	❑	780.2	Fainting
❑	❑	❑	780.79	Fatigue
❑	❑	❑	780.6	Fever
❑	❑	❑	784.0	Headache
❑	❑	❑	780.52	Loss of Sleep
❑	❑	❑	783	Loss of Weight
❑	❑	❑	799.2	Nervousness
❑	❑	❑	729.2	Neuralgia
❑	❑	❑	780.8	Sweats
❑	❑	❑	786.07	Wheezing
❑	❑	❑	311	Depression

Never	Previously	Presently		GASTRO-INTESTINAL
❑	❑	❑	787.3	Belching/Gas/Bloating
❑	❑	❑	789.0	Abdominal Pain
❑	❑	❑	564.0	Constipation
❑	❑	❑	787.91	Diarrhea
❑	❑	❑	783.6	Excessive Eating
❑	❑	❑	575.9	Gall Bladder Trouble
❑	❑	❑	455	Hemorrhoids (piles)
❑	❑	❑	782.4	Jaundice
❑	❑	❑	794.8	Liver Trouble
❑	❑	❑	787.02	Nausea
❑	❑	❑	536.9	Stomach Pain
❑	❑	❑	783.0	Poor Appetite
❑	❑	❑	536.8	Poor Digestion
❑	❑	❑	787.03	Vomiting
❑	❑	❑	578.0	Vomiting Blood
❑	❑	❑	783.5	Excessive Thirst
❑	❑	❑	536.8	Indigestion
❑	❑	❑	569.3	Rectal Bleeding

Never	Previously	Presently		EYE/EAR/NOISE/THROAT
❑	❑	❑	493.9	Asthma
❑	❑	❑	378.9	Crossed Eyes
❑	❑	❑	389.9	Deafness
❑	❑	❑	388.70	Earache
❑	❑	❑	388.60	Ear Discharge
❑	❑	❑	388.30	Ear Noises
❑	❑	❑	240.9	Enlarged Thyroid
❑	❑	❑	460	Frequent Colds
❑	❑	❑	477	Hay Fever
❑	❑	❑	784.49	Hoarseness
❑	❑	❑	478.1	Nasal Obstruction
❑	❑	❑	784.7	Nosebleeds
❑	❑	❑	379.91	Pain in Eyes
❑	❑	❑	368.9	Poor Vision
❑	❑	❑	461.9	Sinusitis
❑	❑	❑	462	Sore Throat
❑	❑	❑	463	Tonsillitis
❑	❑	❑	786.2	Persistent Cough
❑	❑	❑	787.2	Difficulty Swallowing
❑	❑	❑	523.8	Bleeding Gums

Never	Previously	Presently		RESPIRATORY
❑	❑	❑	786.50	Chest Pain
❑	❑	❑	786.2	Chronic Cough
❑	❑	❑	786.09	Difficulty Breathing
❑	❑	❑	786.3	Spitting Blood
❑	❑	❑	786.4	Spitting Phlegm

GENITO-URINARY

❑	❑	❑	788.36	Bed Wetting
❑	❑	❑	599.7	Blood in Urine
❑	❑	❑	788.4	Frequent Urination
❑	❑	❑	788.3	Lack of Bladder Control
❑	❑	❑	590.9	Kidney Infection
❑	❑	❑	788.1	Painful Urination
❑	❑	❑	601.9	Prostate Trouble

				MUSCLES/JOINTS/BONES
❑	❑	❑	724.5	Backache
❑	❑	❑	719.7	Foot Trouble
❑	❑	❑	550	Hernia
❑	❑	❑	719.1	Pain Between Shoulders
❑	❑	❑	724.6	Painful Tail Bone
❑	❑	❑	723.9	Stiff Neck
❑	❑	❑	781.9	Spinal Curvature
❑	❑	❑	719.0	Swollen Joints
❑	❑	❑	781.0	Tremors/Twitching
❑	❑	❑	782	Arm Trouble

				CARDIO-VASCULAR
❑	❑	❑	401.9	High Blood Pressure
❑	❑	❑	458.9	Low Blood Pressure
❑	❑	❑	786.51	Pain Over Heart
❑	❑	❑	785.9	Poor Circulation
❑	❑	❑	438	Previous Heart Trouble
❑	❑	❑	785.0	Rapid Heart
❑	❑	❑	427.89	Slow Heart
❑	❑	❑	436	Strokes
❑	❑	❑	719.7	Swelling Ankles
❑	❑	❑	454	Varicose Veins

				SKIN OR ALLERGIES
❑	❑	❑	680.9	Boils
❑	❑	❑	924.9	Bruising Easily
❑	❑	❑	701.1	Dryness
❑	❑	❑	691.8	Eczema
❑	❑	❑	708.9	Hives or Allergy
❑	❑	❑	698.9	Itching
❑	❑	❑	782.0	Sensitive Skin
❑	❑	❑	782.1	Skin Eruptions

				FOR WOMEN ONLY
❑	❑	❑	625.3	Cramps or Backaches
❑	❑	❑	626.2	Excessive Flow
❑	❑	❑	627.2	Hot Flashes
❑	❑	❑	626.4	Irregular Cycle
❑	❑	❑	634.9	Miscarriage
❑	❑	❑	625.3	Painful Periods
❑	❑	❑	623.5	Vaginal Discharge
❑	❑	❑	611.79	Lump in Breast
❑ Yes	❑ No			Pregnant at this time?
❑ Yes	❑ No			Have you had a mammogram?
_____				Last Pap Smear Date
_____				By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other: _____	_____	Other: _____	_____	Other: _____

❑ I have never had any operations / surgeries

List any accidents or falls and dates: ❑ Car:_____ ❑ Recreation:_____

❑ Sports:_____ ❑ School:_____ ❑ Other:_____

List any broken bones (fractures) or dislocations:_____

Ever on crutches? ❑ Yes ❑ No Why?_____

Have you ever had any spinal taps or spinal injections? ❑ Yes ❑ No Were you ever knocked unconscious? ❑ Yes ❑ No

Have you ever had a lapse of memory? ❑ Yes ❑ No

Have you ever had X-rays taken? ❑ Yes ❑ No When?_____ By Whom?_____

For what ailments were these X-rays made?_____

Do you suffer from any condition other than that for which you are now consulting us?_____

Are you presently taking any medication - prescription or over-the-counter? ❑ Yes ❑ No What drugs?_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X_____ Date:_____

ALIGN CLINIC & ASSOC. PC TEL. 770-532-CARE (2273)

Patient Name: _____ **DOB:** _____ **Age:** _____

Health Risk Assessment:

Smoking: ☐Yes ☐No ☐Never a Smoker ☐ Used to Smoke Quit year? _____

High Cholesterol ☐Yes ☐No ☐ Borderline Last Lab Date: _____ Doc:_____ Is it controlled? ☐Yes ☐No

Medication (s): _____

High Blood Pressure ☐Yes ☐No ☐ Borderline Last Lab Date: _____ Doc:_____ Is it controlled? ☐Yes ☐No

Medication (s): _____

High Sugar ☐Yes ☐No ☐ Borderline Last Lab Date: _____ Doc:_____ Is it controlled? ☐Yes ☐No

Medication (s): _____

Do you have a Thyroid Condition? ☐Yes ☐No Medication: _____ Diagnosed Year? _____

Have you had thyroid Surgery? ☐Yes ☐No

Hyperthyroid: Diagnosed Date: _____ Medication List: _____

Hypothyroid: Diagnosed Date: _____ Medication List: _____

Do you have uncontrolled Hypertension? ☐Yes ☐No

Have you ever been diagnosed with Congestive Heart Failure? ☐Yes ☐No

Have you ever been diagnosed with Chronic Obstructive Pulmonary Disease? ☐Yes ☐No

Physical Activity ☐Yes ☐No ☐Some, please describe: _____

Poor Nutrition? ☐Yes ☐No If Yes describe: _____

Do you think you have excess body fat, especially at the waist? ☐Yes ☐No

Is your Diet high in Saturated fats? ☐Yes ☐No Describe: _____

Any recent or sudden Gain or Lose in Weight? ☐Yes ☐No If yes, how much: _____

Any Family History of heart, hypertension, stoke, mini stroke? ☐Yes ☐No

If Yes (describe): _____

Diabetes? ☐Yes ☐No If Yes (describe when you were diagnosed and medications or supplement your taking: _____

Pulmonary Hypertension ☐Yes ☐No

Taking any Medications for Heart or Diabetes? ☐Yes ☐No If yes List all Medications: _____

Do you have HIV or AIDS? ☐Yes ☐No Diagnosed year: _____ Which Doctor? _____

Any use of other Medication Drugs or Street Drugs? _____

Any previous or current use of Birth Control pills or Hormone Therapy? ☐Yes ☐No

If Yes please describe: _____

Any history of Headaches, Nausea, Vomiting? ☐Yes ☐No If yes please describe: _____

Any history of TIA's (Transient Ischemic Attack? ☐Yes ☐No How many? _____ Began? _____

Have you had a Stroke (CVA- Cerebral Vascular Accident)? ☐Yes ☐No What year? _____

Do you have or had any of the following symptoms? ☐Dizziness ☐Severe Headache ☐Hiccups ☐Nausea (stroke)

Any problems with Sleeping, Sleep Apnea, Unsteadiness, Vertigo, Trouble Speaking, Confusion, Dizziness, Lack of Balance, Lack of Coordination, Trouble Seeing in one or both eyes, Walking problems? ☐Yes ☐No

If yes please describe: _____

Any sudden head or neck pain which is different from any other pain you have had before? ☐Yes ☐No

If yes please describe: _____

Any Fatigue or Weakness of upper arms? ☐Yes ☐No Describe: _____

Any Numbness or Weakness in the face? ☐Yes ☐No Describe: _____

Any Numbness, Weakness, Body general Fatigue? ? ☐Yes ☐No Describe: _____

Do you drink alcohol? ☐Yes ☐No How much? _____ How Often? _____

Are you Pregnant? ☐Yes ☐No If yes, How many weeks? _____ How many Months? _____

Any previous pregnancies? ☐Yes ☐No How many: _____ When? _____ Boys# ____ Girls# ____

Any history of Depression? ☐Yes ☐No If yes, when were you diagnosed? _____

Have you previously or currently taking medication for depression? List: _____

* Do you feel Healthy? ☐Yes ☐No

On a scale 1- 10 mark how you rate your Overall health on average the last 3 months.

(Not healthy-I feel Bad) 1 2 3 4 5 6 7 8 9 10 (Very healthy- I feel Good)

Reviewed by Physician: _____ Date: _____

PATIENT INFORMATION **ACCT:** _____

NAME: _____
DOB: _____
AGE: _____
ETHNICITY: CAUCASIAN HISPANIC AFRICAN AMERICAN ASIAN
INFANT CHILD ADOLESCENT ADULT
MALE FEMALE

SMOKER: YES NO
PACE MAKER: YES NO
METAL IMPANTS: YES NO NOTE: _____
P.C.P: _____ LOCATION: _____
OTHER DOC'S; _____
DOMINANT HAND: LEFT RIGHT AMBIDEXTROUS
ALLERGIES: DRUGS / LATEX OR BOTH
ALLERGIES SEASONAL: YES NO
LAST LAB TESTING: DATE: _____ DOCTOR: _____
RESULTS: _____
FAMILY HISTORY: MOTHER: _____
FATHER: _____
BROTHERS: _____
SISTERS: _____
MATERNAL GRANDPARENTS: _____
PATERNAL GRANDPARENTS: _____
ACCIDENTS:
MOTORVEHICLE: _____
WORK: _____
SPORTS: _____
SURGERIES: YES NO NOTE: _____
DISCLOCATIONS: YES NO NOTE: _____
FRACTURES: YES NO NOTE: _____
WORK: PARTIME FULLTIME
PLACE OF EMPLOYMENT: _____
STUDENT: PARTIME FULLTIME
SCHOOL: _____

_____ _____
ATTENDING PHYSICIAN DATE

Algin Clinic Associates, P.C.

Medical history

Patient:_____ DOB:_____

Past Medical History/ Problem List

Medications

Past Surgical History

Family History

Health Maintenance

Procedure	Date	Date	Date
Pap Smear			
Mammogram			
Rectal			
Prostate			
Colonoscopy			
Visual Acuity			
Hearing			
FLU			
TETANUS			
PNEUMOVAX			

Social History

Allergies/ Reactions

Hospitalizations

4327 Mundy Mill Road, Suite A Oakwood, GA 30566 Phone:770-532-(CARE)2273 Fax: 770-532-5988
E-mail: Aligncareclinic@gmail.com Web: www.AlignCareClinic.com

Mobile Thermographic Imaging

Janique Cook | Angelique Scibetta | Owners & Certified Clinical Thermographers
MTI C.C.T. Team | Brandy Jackovitch | Loren Scibetta | Alia Faber | Gabriella Viamonte
(678)688-8986 | mti.thermography@gmail.com | www.Atlanta-Breast-Thermography.com

LOCATION:_____
Regions Scanned:_____
Thermographer:_____

Full Body Study Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Name:_____ DOB:_____

Address:_____ City_____ State_____ Zip_____

Phone:_____ Your Doctor: Dr. Sandra De Sousa

Please Show areas of:

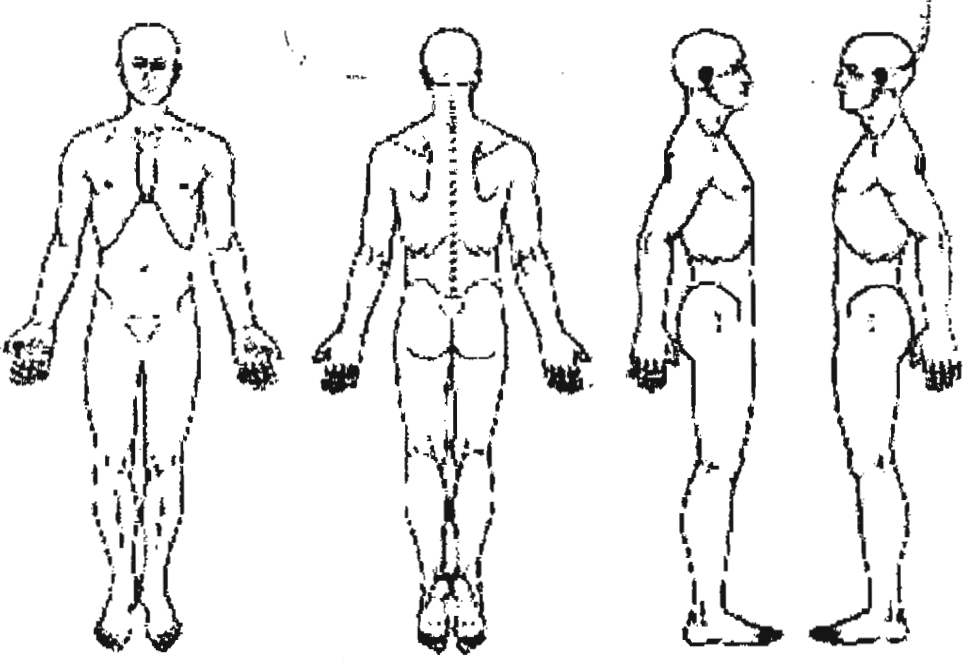
Main Pain *

Secondary Pain O

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring



Do you know what triggered the pain?_____

Does anything relieve it?_____

Does anything aggravate it?_____

Has it changed since it began?_____

Have you had any treatment?_____

History: Injuries / Fractures / Surgery_____

_____

CLIENT/PATIENT DISCLOSURE: I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

SIGNATURE_____ DATE_____

Align Care Clinic

Medical History Form

Name:_____ Date:_____ Age: _____

Please indicate if YOU have a history of the following medical problems:

Diabetes (Sugar)	Yes( ) No( )	Heart Disease	Yes( ) No( )	Kidney/Bladder	Yes( ) No( )
Arthritis	Yes( ) No( )	Seizures/Epilepsy	Yes( ) No ( )	Cancer	Yes( ) No( )
High Blood Pressure	Yes( ) No( )	Colon/Ulcer	Yes( ) No( )	Lung Disease	Yes( ) No( )

Any other conditions not listed?_____

_____

_____

Please List Past Surgeries:_____

_____

Please List Current Medications:_____

_____

Are you **allergic** to any medications? Yes( ) No( )

_____

If you are a female, are you pregnant? Yes( ) No( )

Please indicate if you have any **Family Members** with history of the following medical problem:

Diabetes (Sugar)	Yes( ) No( )	Heart Disease	Yes( ) No( )	Kidney/Bladder	Yes( ) No( )
Arthritis	Yes( ) No( )	Seizures/Epilepsy	Yes( ) No ( )	Cancer	Yes( ) No( )
High Blood Pressure	Yes( ) No( )	Colon/Ulcer	Yes( ) No( )	Lung Disease	Yes( ) No( )

Any other conditions listed?_____

_____

Do you smoke? Yes( ) No( ) Do you drink alcohol? Yes( ) No( )

Do you use any recreational drugs? Yes( ) No( ) if so, what?_____

_____

Are you employed? Yes( ) No( ) Occupation:_____

Are you disabled? Yes( ) No( )

Signature_____ Date___/___/_____