PATIENT INFORMATION

Albuquerque Alternative Health New Patient Intake Paperwork

Legal Name: (Last) ___________________________ (First) ____________________________ (Middle Initial) ___________

Email: ___________________________________ Primary Phone: __________________ Home ___ Cell ____ Work ___

Address: ____ City: ______________________________

State: ____________________ Zip: ______________ Sex: M___ F ___ Age: _______ Birth Date: ______________

Married: ___ Single: ___ Partnered: ___ Widowed: ___ Divorced: ___ Children? _______ How Many? _____

Occupation: __________________________________ Employer/School: _____________________________________

In case of emergency, Contact: (First Name) ________________________ (Last Name) ___________________________

Relationship: ______________________________ Phone: ___________________________

PAYMENT / INSURANCE INFORMATION

Have you seen a Chiropractor before? Yes ____ No ____ If yes, how many times (Approx.) ______________

Albuquerque Alternative Health does not accept commercial insurance.

Did you purchase a Groupon? Yes ____ No ____ Did you receive a Flyer? Yes ____ No ____

What is the Groupon redemption Code (5-8 digits)? _________________________________

Did you receive a Gift Certificate? Yes ___ No ___ From who? ___________________________________

Did you make your appointment from our Facebook Ad? Yes _____ No _____

Other? Yes ___ No ___ If so, please specify: ____

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1) certify that the information on this form is accurate and up to date. 2) Consent to treatment by Albuquerque Alternative Health. 3) Agree to be primarily responsible for all charges owed to Albuquerque Alternative Health (other than those included in any pre-paid offer), including attorney fees, court cost and other expenses of collections. 4) Consent to Albuquerque Alternative Health releasing any "protected health information," as defined by federal HIPPA regulations, for the purposes allowed by law. 5) Acknowledge receipt of Albuquerque Alternative Health's Notice of Privacy Practices

____ ____

Printed name of patient, parent, guardian or personal representative Signature of patient, parent, guardian or personal representative

Relationship: ____ Date: ____

MEDICATIONS ***VITAMINS / SUPPLEMENTS*** ***ALLERGIES***

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Medications	Vitamins / Supplements	Allergies
1) ___________________________	1) ___________________________	1) ____________________________
2) ___________________________	2) ___________________________	2) ____________________________
3) ___________________________	3) ___________________________	3) _____________________________
4) ___________________________	4) ___________________________	4) ____________________________
None: _________	**Daily ____ Weekly ____ Occasionally ____**	How often do they occur?
		None: ____

FAMILY HISTORY

Auto immune Dis. Yes ___ No ___ Bleeding Dis. Yes ___ No ___ High Blood Pressure Yes ___ No ___ Migraines Yes ___ No ___
Diabetes Yes ___ No ___ Heart Disease Yes ___ No ___ Osteoporosis Yes ___ No ___ Stroke Yes ___ No ___
Clotting Disorder Yes ___ No ___ Kidney Disease Yes ___ No ___ Thyroid Disease Yes ___ No ___ Cancer Yes ___ No ___
Other: ____

MEDICAL HISTORY

Name and phone number of other Doctor(s):
____
Date of Last: Physical Exam _____________ Spinal X-Ray ____________ Spinal Exam _____________ Chest X-Ray _____________
MRI, CT-Scan __________________ Bone Scan _________________ Blood Test ________________ Urine Test __________________

Mark "Yes" or "No" to indicate whether you have experienced any of the following and complete the information below:

AIDS/HIV Yes ___ No ___ Chemical Depend. Yes ___ No ___ Hernia Yes ___ No ___ Pinched Nerve Yes ___ No ___
Allergies Yes ___ No ___ Alcoholism Yes ___ No ___ Herniated Disc Yes ___ No ___ Pneumonia Yes ___ No ___
Anemia Yes ___ No ___ Chicken Pox Yes ___ No ___ Hypertension Yes ___ No ___ Prostate Problem Yes ___ No ____
Anxiety/Depress. Yes ___ No ___ Clotting Disorder Yes ___ No ___ Kidney Disease Yes ___ No ___ Psychiatric Care Yes ___ No __
Appendicitis Yes ___ No ___ Diabetes Yes ___ No ___ Liver Disease Yes ___ No ___ Rheum. Arthritis Yes ___ No ___
Arthritis Yes ___ No ___ Eating Disorder Yes ___ No ___ Migraines Yes ___ No ___ STD Yes ___ No ___
Asthma Yes ___ No ___ Emphysema Yes ___ No ___ Mononucleosis Yes ___ No ___ Stroke Yes ___ No ___
Autoimmune Dis. Yes ___ No ___ Epilepsy/Seizure Dis. Yes ___ No ___ MS Yes ___ No ___ Thyroid Disease Yes ___ No ___
Bleeding Disorder Yes ___ No ___ Headaches Yes ___ No ___ Osteoporosis Yes ___ No ___ Tuberculosis Yes ___ No ___
Bronchitis Yes ___ No ___ Heart Disease Yes ___ No ___ Pacemaker Yes ___ No ___ Tumors, Growths Yes ___ No ___
Cancer Yes ___ No ___ Hepatitis Yes ___ No ___ Parkinson's Yes ___ No ___ Ulcers Yes ___ No ___
Are you Pregnant? Yes ___ No ___ If yes, how many weeks? _______________ Other: _____________________________________

PHYSICAL AND TRAUMA INFORMATION

Please indicate any physical and/or trauma occurrences below, making sure to note any minor injuries as well by checking "Yes". Please describe when applicable.

Work Activities: Sitting _____ Standing _____ Light Labor _____ Heavy Labor _____ Retired _________________________

Work Injuries Yes ___ No ___ If Yes: ____

Sports Activities: ____

Sports Injuries: Yes ___ No ___ If Yes: ____

Exercise: None _____ Light _____ Moderate ______ Heavy ____

Habits: Nicotine _____ Alcohol _____ Coffee/Caffeine Drinks _____ High Stress Level _____ None _____

How Much? ________________________________ How Often? Daily _____ Weekly _____ Occasionally _____

Falls: Yes ___ No ___ If Yes: ___________________________ Dislocations: Yes ___ No ___ If Yes: _________________________

Head Injuries: Yes ___ No ___ If Yes: _____________________ Broken Bones Yes ___ No ___ If Yes: _______________________

Surgeries: Yes ___ No ___ If Yes: ____

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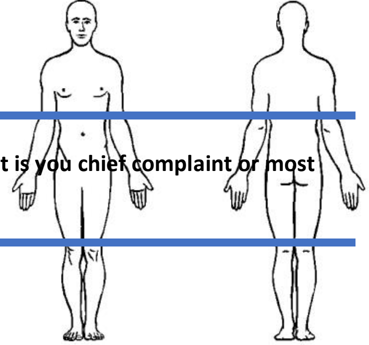


PRIMARY COMPLAINT **Please note one complaint in the following section. The primary complaint is you chief complaint or most problematic concern at this time that brought you in today.**

Primary complaint: ____

Please describe the condition: ____

When did your symptoms first appear? ____

What do you think caused this problem? ____

Mark an X on the Picture where you have pain, numbness or tingling:

Rate the severity of your pain … At its worst: (Least Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

(Please Circle) … At its least severe: (Least Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

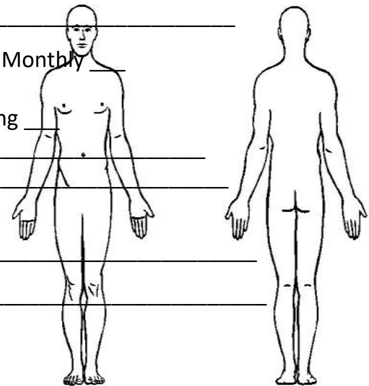
… At present moment: (Least Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Type of Pain: Sharp ___ Dull ___ Throbbing ___ Numbness___ Aching ___ Shooting ___ Burning ___

ADDITIONAL COMPLAINT **Please note ONE complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.**

Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other _________________________

Does the pain travel from one location to another? Yes ___ No ___ From where to where? ___________________________



How often do you have this pain? Constantly ___ Comes and goes ___ Infrequently ___ Daily ___ Weekly ___ Monthly ___

Do activities make it worse in: AM ___ PM ___ N/A ___

Which activities are affected by this? Work ___ Sleep ___ Daily Routine ___ Recreation ___ Sitting ___ Standing ___

Walking ___ Bending ___ Lying Down ___ Other ____

Past treatments: Medications ___ Surgery ___ Physical Therapy ___ Chiro Services ___ None ___ Other _______________________

Were they successful? Yes ____ No ___

Pain worsens with: ____________________________ Pain improves with: ____________________________

Notes: ____

Additional complaint: ____

Please describe the condition: ____

When did your symptoms first appear? ____

What do you think caused this problem? ____

Mark an X on the Picture where you have pain, numbness or tingling:

Rate the severity of your pain … At its worst: (Least Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

(Please Circle) … At its least severe: (Least Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

… At present moment: (Least Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Type of Pain: Sharp ___ Dull ___ Throbbing ___ Numbness___ Aching ___ Shooting ___ Burning ___

Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other _________________________

Does the pain travel from one location to another? Yes ___ No ___ From where to where? ____________________________________

IS THERE ANYTHING ELSE YOU WOULD LIKE DR. DOWNS TO KNOW?

How often do you have this pain? Constantly ___ Comes and goes ___ Infrequently ___ Daily ___ Weekly ___ Monthly ___

Do activities make it worse in: AM ___ PM ___ N/A ___

Which activities are affected by this? Work ___ Sleep ___ Daily Routine ___ Recreation ___ Sitting ___ Standing ___
Walking ___ Bending ___ Lying Down ___ Other ____

Past treatments: Medications ___ Surgery ___ Physical Therapy ___ Chiro Services ___ None ___ Other _________________________
Were they successful? Yes ____ No ___

Pain worsens with: _____________________________________ Pain improves with: ____

Notes: ____

Albuquerque Alternative Health New Patient Paperwork

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FOR OFFICE USE ONLY

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