Patient Name_____ Date: _____

New Practice Member Forms
Adult (7 yrs +)

Name_____ Date of Birth_____/_____/_____ Age____ Male/Female

Address_____ City_____ State_____ Zip_____

Cell Phone Number_____ Home or Work Number_____

Email Address_____ Do you have insurance? ___Yes ___No

Social Security #_____ Driver's License #_____

Occupation_____ Employer's Name_____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages, & Gender_____

Name & Phone # of Emergency Contact _____

Relationship to Emergency Contact _____

Who may we thank for referring you?_____

Health Conditions

Please identify the health concern(s) that brought you into this office:

Primary:_____ **Second:**_____

Third:_____ **Fourth:**_____

On a scale of 0 to 10 with 10 being the worst and 0 being no pain, rate the above complaints by circling the #:

Primary complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

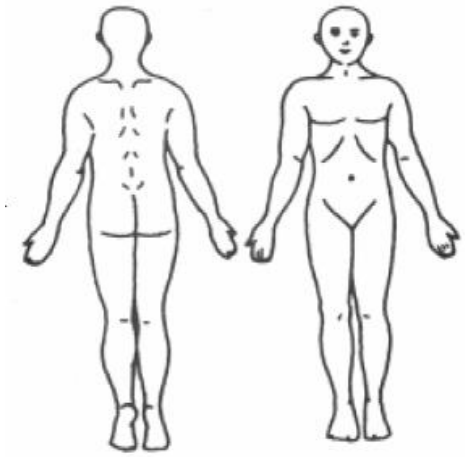
When did your primary complaint begin?_____

How did the complaint happen? _____

Is your complaint the result of ANY type of accident? ___Yes ___No

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A = A**ching
T = Tingling **N = N**umbness **S = S**harp/Stabbing



Patient Name _____ Date_____

Please identify all past and any **current** conditions you feel may be contributing to your primary complaint:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY
INJURIES			
SURGERIES			

Review of Systems

Please mark: **P** for in the **Past** **C** for **Currently** have

___ Headache ___ Pregnant (Now) ___ Dizziness ___ Prostate Problems

___ Ulcers ___ Neck Pain ___ Frequent Colds/Flu ___ Loss of Balance

___ Jaw Pain, TMJ ___ Convulsions/Epilepsy ___ Heartburn ___ Impotence/Sexual Dysfun.

___ Fainting ___ Digestive Problems ___ Heart Problem ___ High/Low Blood Pressure

___ Shoulder Pain ___ Tremors ___ Double Vision ___ Colon Trouble

___ Upper Back Pain ___ Chest Pain ___ Blurred Vision ___ Diarrhea/Constipation

___ Mid Back Pain ___ Pain w/Cough/Sneeze ___ Ringing in Ears ___ Hepatitis (A,B,C)

___ Asthma ___ Low Back Pain ___ Foot or Knee Problems ___ Hearing Loss

___ Menstrual Issues ___ Difficulty Breathing ___ Hip Pain ___ Sinus/Drainage Problem

___ Depression ___ Lung Problems ___ Irritability ___ Swollen/Painful Joints

___ Bed Wetting ___ Kidney Trouble ___ Scoliosis ___ Skin Problems

___ Mood Changes ___ Learning Disability ___ ADD/ADHD ___ Gall Bladder Trouble

___ Eating Disorder ___ Liver Trouble ___ Allergies ___ Trouble Sleeping

___ Numb/Tingling legs, feet, toes ___ Numb/Tingling arms, hands, fingers

___Other: _____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have

___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability

___Cancer ___Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular

___Other serious conditions: _____

Patient Name _____ Date_____

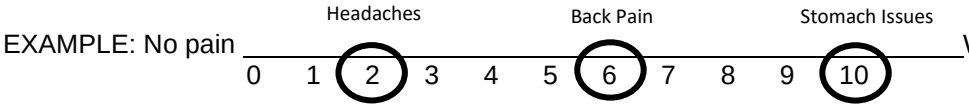
Medications

List any prescription & non-prescription drugs you take: _____

_____

Quadruple Visual Analogue Scale

Instructions: Please circle the number that best describes the question being asked.
Note: If you have more than one complaint, answer each question for each individual complaint and indicate the score for each. Please indicate your pain level right now, average pain, and pain at its best and worst.



1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Adjusted Life Chiropractic Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Adjusted Life Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____

Patient Name (print)

_____ ____/____/____

Patient or Authorized Person's Signature Date

Patient Name _____ Date_____

HIPAA Personal Health Information Release Authorization

I, _____, hereby authorize Adjusted Life Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ○ Spouse Name: _____
- ○ Significant Other Name: _____
- ○ Parent/Legal Guardian Name: _____
- ○ Child(ren) Name(s): _____
- ○ Any Specified Person Name: _____
- ○ Information is not to be discussed with or released to anyone.

Restrictions:

- ○ No Restrictions
- ○ Only discuss my appointment time with the above-named individual(s).
- ○ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ○ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ○ my home ○ my work ○ my cell phone Phone Number: _____ - _____ - _____
If unable to reach me:

- ○ you may leave a detailed message
- ○ please leave a message asking me to return your call

I understand I may terminate this consent at any time by giving written notice to Adjusted Life Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to: 1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2. Obtain payment from third-party payers. 3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature _____ Date _____

Patient Name _____ Date_____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is $10.00.** This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Adjusted Life Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

Print Name _____

Signature _____ Date _____

REGARDING: X-rays / Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____

Patient Name (print)

_____ ____/____/____

Patient or Authorized Person's Signature Date

Adjusted Life Chiropractic

I hereby authorize payment to be made directly to Adjusted Life Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Adjusted Life Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**