Adjust Life
we listen we care we get results

Patient Information

Date _____

First Name: _____ Last Name: _____ Initial _____

Major Complaint Information

List chief symptoms in order of severity:

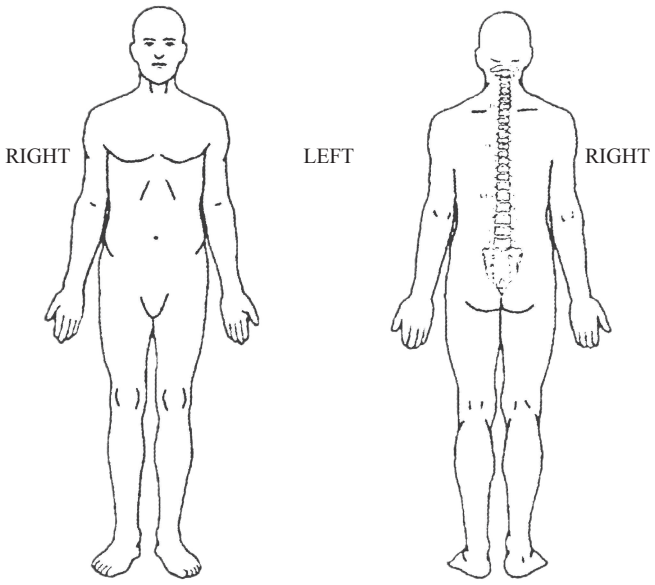
(1) _____ (2) _____

(3) _____ (4) _____

When did this symptom(s) begin? _____

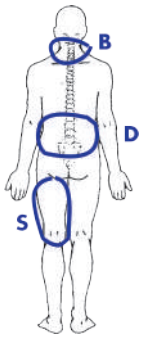
What started the complaint? _____

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.



Pain Index

D Dull Nagging Ache
B Burning
S Sharp / Stabbing
N Numbness / Tingling



For example: The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.

Severity

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain imaginable, use the key to the right to rate the severity of your pain.

What is the intensity of the pain that brings you in today on a scale of 0-10? (Please circle)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Frequency? (Please circle)

Constant ☐ Frequent ☐ Intermittent ☐ On & Off ☐ Random ☐

Is it getting: ☐Better ☐Same ☐Worse

Previous Care: What have you done for this? _____

_____

Have you experienced these symptoms before? ☐Yes ☐No

When? _____

What aggravates this condition? _____

What decreases the symptoms / pain? _____

Key

0 = None
1 = Minimal
2 = Very Mild
3 = Mild
4 = Mild to Moderate
5 = Moderate
6 = Moderate to Severe
7 = Moderately Severe, Restricts some activity
8 = Severe, Limits most activity
9 = Very Severe
10 = Excruciating

Have you seen anyone else for this condition? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Have you seen a chiropractor before? ☐ Yes ☐ No

Name of chiropractor(s): _____ Date(s) consulted: ____/____/____ - ____/____/____

Does this condition interfere with your sleep? ☐ Yes ☐ No If so, how many times do you wake up in pain per night?_____

In what position do you sleep? ☐ Back ☐ Side ☐ Stomach

Check those activities below during which experience difficulty or pain:

☐ Lying on back	☐ Driving	☐ Pulling	☐ Sitting	☐ Standing for long periods
☐ Lying on side	☐ Getting in/out of car	☐ Reaching	☐ Bending forward	☐ Sneezing
☐ Turning over in bed	☐ Dressing Self	☐ Lifting	☐ Bending backward	☐ Coughing
☐ Lying flat on stomach	☐ Sexual Activity	☐ Kneeling	☐ Turning/Twisting	☐ Caring for family
☐ Computer use	☐ Pushing	☐ Squatting	☐ Walking	☐ Other: _____

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Lower Back Pain

Does pain radiate into the leg? ☐ Yes ☐ No Where: _____ Does pain radiate to the abdomen? ☐ Yes ☐ No

Do you ever have impairment of bowel or urinary function? ☐ Yes ☐ No Explain: _____

Do you have numbness or tingling into the legs? ☐ Yes ☐ No Explain: _____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) ☐ Hearing ☐ Vision ☐ Balance ☐ Cause ringing in your ears

Do you hear grating sounds? ☐ Yes ☐ No Do you feel pressure or pain behind your eyes? ☐ Yes ☐ No

Does pain radiate into the arm? ☐ Yes ☐ No Where: _____

Do you have difficulty lifting or turning your head? ☐ Yes ☐ No If so, in which direction? ☐ Right ☐ Left ☐ Up ☐ Down

Headaches

Do you get headaches? ☐ Yes ☐ No Frequency _____ Do you have a family history of headaches? ☐ Yes ☐ No

Do you experience the following along with your headaches: Pain or cracking in your jaw? ☐ Yes ☐ No

Abnormal blood pressure? ☐ Yes ☐ No ☐ High ☐ Low Nausea, Vomiting or Visual disturbances? ☐ Yes ☐ No

When was your last eye exam by a doctor? ☐ 1 - 6 months ☐ 6 - 12 months ☐ 1 - 2 years ☐ over 2 years Results:

If female, are you pregnant? ☐ Yes ☐ No ☐ Not Sure If no or not sure, date of your last menstrual period:_____

List all medications you are taking now, including over the counter medication. _____

_____

Are you allergic to any medications? ☐ Yes ☐ No ☐ Not Sure Please list: _____

_____

Have you ever had any surgeries or hospitalizations? ☐ Yes ☐ No Please list:

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed or received MRI, CAT scan in the last 12-18 months? ☐ Yes ☐ No When?: _____

Do you have a family physician? ☐ Yes ☐ No

Name of physician: _____ Phone: _____

May we forward our findings to your family physician? ☐ Yes ☐ No

Additional Complaints

Please check all additional complaints that you have at this time:

- ☐ Loss of Concentration
- ☐ Eyes Sensitive to Light
- ☐ Memory Loss
- ☐ Heavy Feeling of Head
- ☐ Dizziness/Loss of Balance
- ☐ Ringing in Ears
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Pain Behind Eyes
- ☐ Fainting
- ☐ Palpitation
- ☐ Fever
- ☐ Neck Stiffness
- ☐ Neck Motion Restricted
- ☐ Upper Back Pain / Stiffness
- ☐ Mid Back Pain / Stiffness
- ☐ Right / Left Shoulder Pain
- ☐ Right / Left Arm Pain
- ☐ Pins & Needles Arms / Legs
- ☐ Right / Left Leg Pain
- ☐ Low Back Pain/Stiffness
- ☐ Sinus Trouble
- ☐ Nervousness
- ☐ Chest Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Shortness of Breath
- ☐ Irritable
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Night Pain
- ☐ Fatigue
- ☐ Excess Perspiration
- ☐ Digestive Trouble
- ☐ Nausea
- ☐ Headache
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Jaw pain
- ☐ Hypertension
- ☐ Diabetes
- ☐ Convulsions
- ☐ Allergies (Please List)

_____

_____

_____

- ☐ Vision Problems
- ☐ Anemia
- ☐ Heart Disease
- ☐ Blood in Urine
- ☐ Pain Unrelieved by Rest
- ☐ Arthritis
- ☐ HIV (Aids)
- ☐ Other (Please List)

_____

_____

Please Specify Location:

- ☐ Numbness/Tingling

_____

- ☐ Swelling _____
- ☐ Cuts _____
- ☐ Bruising _____

Do you have, or have you ever had, any diseases or medical problems not listed? ☐ Yes ☐ No If so, please list: _____

_____

Have you ever had? ☐ Motor Vehicle Injury ☐ Sports Injury ☐ Work Injury ☐ Slip and Fall Injury

If yes, please explain: _____

Is there any additional information you would like the doctor to know about before beginning care? _____

_____

_____

Personal and Social History

Immediate Family History of illness: _____

_____

Do you have a history of smoking/vaping? ☐ Yes ☐ No

Do you currently smoke/vape? ☐ Yes ☐ No If yes, how often per day/week? _____

Drink Caffeine? ☐ Yes ☐ No If yes, how often per day/week? _____

Drink Alcohol? ☐ Yes ☐ No If yes, how often per day/week? _____

How many days a week do you exercise? _____ Type of exercise: _____

Any dietary modifications or restrictions? _____

_____

Emergency Contact

Name: _____ Relation: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Address: _____

_____

Personal Information

Address: _____

City / State / Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Mobile Phone: ( ) _____ Email: _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Occupation: _____ Employer's Name: _____

Work Address: _____

City / State / Zip: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse's Name: _____ # of Children: _____

_____

How were you referred to Adjust Life? _____

_____

Authorization & Assignment

I authorize Adjust Life to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you, and after 120 days of non-payment Adjust Life will transfer my case over to a collection agency if there has been no communication by me regarding my balance.

I, the undersigned do hereby appoint Adjust Life authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date _____ Patient's Signature _____

Informed Consent

I hereby authorize physicians and staff at Adjust Life to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Adjust Life responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication that people are concerned about with chiropractic treatment. The most recent show that you are no more likely to have a stroke from seeing a chiropractor than you are from seeing a medical doctor. There has not been shown to have any caused link between chiropractic manipulation & stroke.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date _____ Patient's Signature _____