Patient Name_____ Date: _____

New Practice Member Application

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 this problem start?_____

How did the injury happen? _____

When is the problem at its worst? ___AM ___PM ___Mid-Day ___Late PM

How long does it last? ___Constant ___On & off during the day ___Comes & goes throughout the week

Have you ever seen other doctors for these conditions? ___Yes ___No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

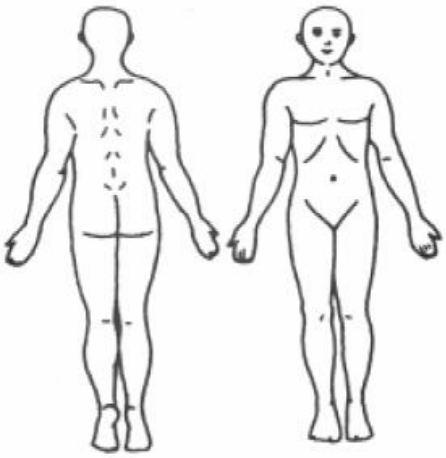
Is your condition(s) the result of ANY type of accident? ___Yes ___No

Identify any other injury(s) to your spine, minor or major: _____

_____

Patient Name _____ Date_____

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 = T**ingling
N = Numbness **S = S**harp/Stabbing

What relieves your symptoms: _____

_____

What makes your symptoms feel worse? _____

_____

Please identify how your current condition(s) is affecting your ability to carry out activities part of your life:

LIST RESTRICTED ACTIVITY	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems

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

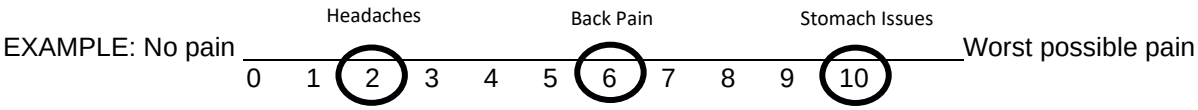
___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems
___ Ulcers	___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Heartburn	___ Impotence/Sexual Dysfun.
___ Fainting	___ Digestive Problems	___ Heart Problem	___ High/Low Blood Pressure
___ 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: _____

Patient Name _____ Date_____

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:

Past History

Have you suffered with this or a similar problem in the past? ___ Yes ___No **If yes**, how many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried? ___Yes ___No **If yes**, please state what type of treatment? _____

Who provided it? _____ How long ago? _____

What were the results? ___ Good ___Bad Please explain :_____

Please identify any and all types of jobs you have had in the past that imposed any physical stress on you or your body? _____

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_____

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

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

List all Surgical operations & years: _____

_____

_____

Have you ever been in an auto accident? List accident and year: _____

_____

Medications

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

_____

_____

Family Health History

Does anyone in your family suffer with the same condition(s)? ___No ___Yes, if so, whom?

__Grandmother __Grandfather __Mother __Father __Sister(s) __Brother(s) __Son(s) __Daughter(s)

Have they ever been treated for their condition? ___No ___Yes ___I don't know

Any other hereditary conditions the doctor should be aware of? ___No ___Yes: _____

_____

Social History

Smoking __Cigars __Pipe __Cigarettes **How often?** __Daily __Weekends __Occasionally __Never

Alcohol - How often? __Daily __Weekends __Occasionally __Never

Recreational Drug Use - How often? __Daily __Weekends __Occasionally __Never

Patient Name _____ Date_____

Activities of Daily Life

Please identify how your current condition is affecting your ability to carry out activities routinely part of your life:

ACTIVITY:	**EFFECT:**			
Carry Groceries / Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children / Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing / Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrate / Read	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient Name _____ 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**

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: _____

Patient Name _____ Date_____

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)

_____ ____/____/____ 🗀 *Witness Initials*

Patient or Authorized Person's 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)

_____ ____/____/____ 🗀 *Witness Initials*

Patient or Authorized Person's Signature Date

Patient Name _____ 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 _____

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 _____ Date of Birth _____

Signature _____ Date _____