Adjust Chiropractic
1258 Washington Road
Thomson, GA 30824
Ph (706)-597-0059
Fx (706) 597-9100

PERSONAL INJURY QUESTIONNAIRE

(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS...THANK YOU!)

PATIENT NAME: ____________________ TODAY'S DATE: __________

DATE OF ACCIDENT: ______________ TIME: __________ AM/PM ________

Please describe the accident in your own words: ______________________________________

____

____

____

What street or intersection were you on when the accident occurred? ____________________

What city did the accident occur in? ______________________________________

What direction were you traveling in? ☐ North ☐ South ☐ East ☐ West

Road conditions? ☐ Clear ☐ Dark ☐ Dry ☐ Wet/Rainy ☐ Icy/Snowy ☐ Other ______

Visibility at the time of the accident? ☐ Poor ☐ Fair ☐ Good ☐ Other __________

How many vehicles were involved in the accident? ______________________________

What type of vehicle were you in (year, make, and model)? ______________________

At the time of impact, how fast were you traveling? ______________________________

Was your vehicle... Slowing down Speeding up Moving at a steady speed Stopped Other

What type of vehicle impacted yours (year, make, and model of other vehicle)? ______________

At the time of impact, how fast would you estimate the other vehicle was moving? ____________

What type of impact was the auto accident? (check all that apply) ☐ Head-on Collision
☐ Driver's side Broad-side Collision ☐ Passenger side Broad-side Collision ☐ Front Impact
☐ Rear-ended car in front of you ☐ Rear Impact ☐ Non-Collision

During and after the crash what happened to your vehicle? (Check all that apply) ☐ Kept going straight
☐ Spun around ☐ Kept going straight hitting a car in front of you ☐ Hit a stationary object
☐ Spun around and hit a stationary object ☐ Was hit by another vehicle

Did your vehicle hit anything following the accident? (If so what) ______________________

What was damaged in your vehicle (Check all that apply): ☐ Completely totaled

☐ Windshield ☐ Dashboard ☐ Steering wheel ☐ Mirror ☐ Knee bolster
☐ Front bumper ☐ Front left door ☐ Front right door ☐ Seat frame ☐ Side window
☐ Rear bumper ☐ Back left door ☐ Back right door ☐ Trunk ☐ Rear window

What was the estimated damage to the vehicle you were in? ______________________

Were you wearing a seatbelt? ☐ No ☐ Yes ☐ Shoulder ☐ Lap

Did you slide out of your seatbelt during the accident? ☐ No ☐ Yes

Were you ejected from the vehicle? ☐ No ☐ Yes ______________________

Was vehicle equipped with airbags? ☐ No ☐ Yes ☐ Did they inflate properly? ☐ No ☐ Yes

Patient's Signature: ______________ **Date:** __________ **Dr.'s Signature:** ______________

PATIENT NAME: ____________________ TODAY'S DATE: __________

What kind of headrest was in your vehicle? ☐ Movable fixed ☐ Non-movable fixed ☐ No headrest

Where was the headrest positioned on your head? ____________________

Where were you sitting in the vehicle during the accident? ____________________

Who was the driver of the vehicle? ____________________

Who else was in the vehicle? ____________________

Who owns the vehicle? ____________________

Did you see the accident coming? ☐ No ☐ Yes Did you brace for the impact? ☐ No ☐ Yes

At the time of impact, how was your head positioned? ☐ Looking straight ahead ☐ Looking to the left ☐ Looking to the right ☐ Looking up ☐ Looking down ☐ Looking behind you

At the time of impact, were you wearing a hat or glasses? ☐ No ☐ Yes

If yes, where were they located after the accident? ____________________

At the time of impact, were your hands on the wheel? ____________________

At the time of impact, how was your body positioned? ____________________

At the time of impact, where were your feet positioned? ____________________

During the accident, did any parts of your body hit anything in the car? ☐ No ☐ Yes, please describe: __________

Did you get any bruises? ☐ No. ☐ Yes. Where? ____________________

Did you get any bleeding cuts? ☐ No. ☐ Yes. Where? ____________________

As a result of the accident were you ☐ Rendered unconscious ☐ Dazed, circumstances were vague ☐ In Shock ☐ Other ____________________

Please check any of the following symptoms that you have experienced since the accident:

☐ Headaches	☐ Shoulder Pain	☐ Muscle Spasm/Soreness	☐ Ear Ringing/Buzzing
☐ Facial Pain	☐ Arm Pain	☐ Sleeping Problems	☐ Fatigue
☐ Clicking/Popping Jaw	☐ Wrist/Hand Pain	☐ Light Sensitivity	☐ Irritability
☐ Neck Pain/Stiffness	☐ Leg Pain	☐ Shortness of Breath	☐ Anxiety
☐ Mid Back Pain	☐ Knee Pain	☐ Loss of Balance	☐ Depression
☐ Chest Pain	☐ Ankle/Foot Pain	☐ Lightheadedness/Dizzy	☐ Fainting Spells
☐ Low Back Pain	☐ Arm/Leg Weakness	☐ Diarrhea	☐ Memory Loss
☐ Pelvic/Hip Pain	☐ Numbness/Tingling	☐ Constipation	☐ Visual Disturbances
☐ Nausea/Vomiting	☐ Other ____________		

Did you sustain any injuries that rendered you unable to fulfill your work requirements? (Please explain): ____________________

____

____

How many days of work have you missed? ____________________

Did you go to the hospital? ☐ No ☐ Yes

When did you go to the hospital? ☐ Immediately from the scene of the accident ☐ Later the same day ☐ The next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Drove self ☐ Someone else drove

Patient's Signature: ____________ **Date:** ____________ **Dr.'s Signature:** ____________

PATIENT NAME: ____________________ TODAY'S DATE: ____________

Name of hospital and/or attending doctor: ____________________

Did you stay overnight? ☐ No ☐ Yes. If so, how long was your stay? ____________________

What kind of treatment did you receive at the hospital? ☐ Medications. What kind(s)? ____________________

☐ Neck brace ☐ Cast ☐ Stitches ____________________

☐ X-rays ____________________ ☐ MRI ____________________ ☐ CT scan ____________________

☐ Medications ____________________ ☐ Others ____________________

What benefits did you receive from this treatment? ____________________

Have you seen any other doctor in relation to this accident outside of the ER? ☐ No ☐ Yes

If yes, who, when, and where? ____________________

What treatment did you receive? ____________________

Was the treatment helpful? If so, how has it helped? ____________________

____

Did you file a claim with your insurance company? ☐ No ☐ Yes

Insurance Company Name? ____________________

Adjuster's Name: ____________________

Claim Number: ____________________

Insurance Company Name of Other motorist? ____________________

Adjuster's Name: ____________________

Claim Number: ____________________

Do you have an attorney representing you for this claim? ☐ No ☐ Yes

If yes, who?____________________

Name of Firm? ____________________

I, the undersigned, verify that all of the above information is, to the best of my knowledge, factual and true. By signing below, I take full accountability for the provided information above. I hereby agree to inform Adjust Chiropractic's office manager or treating doctor of any changes regarding my account or medical information. I also understand that ultimately, I am financially responsible for the treatment rendered in relation to this accident.

Patient's Signature and/or Legal Guardian's Signature: ____________________ **Date:** ____________

Witness Name: ____________________ **Witness's Signature:** ____________________ **Date:** ____________

Doctor's Signature: ____________________ **Date:** ____________

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Personal

Today's Date: ______/______/______

Name: First ____________ MI ______ Last ____________ Preferred Name ____________

Address: ____________ Apt. # ______ City ____________ State ______ Zip ______

Mailing Address (If different from above): ____________

DOB: ______/______/______ Age ______ Driver's License # ____________ Male/Female Height: ______ Weight ______

Single Married Divorced Widowed

Cell Ph# (_____) _____-______ Home Ph# (_____) _____-______ Work Ph# (_____) _____-______

Email: ____________@__________.com Status: Student/Employed/Unemployed/Retired

Present Employer: ____________ Occupation: ____________

Emergency Contact: ____________ Ph# (_____) _____-______

Primary Care Physician: Ph# (_____) _____-______

How did you hear about our office (If a person may we thank them for you)? ____________ (Y/N)

Problem List

1. Primary (Main) Complaint: ____________ When did it start? ______ How often? (% of the day) ______

How did the problem begin? ____________ Getting: Worse/Same/Better

What aggravates problem? ____________ What improves problem? ____________

Rate Pain (0=no pain, 10=excruciating pain): 0 1 2 3 4 5 6 7 8 9 10

2. Secondary Complaint: ____________ When did it start? ______ How often? (% of the day) ______

How did the problem begin? ____________ Getting: Worse/Same/Better

What aggravates problem? ____________ What improves problem? ____________

Rate Pain (0=no pain, 10=excruciating pain): 0 1 2 3 4 5 6 7 8 9 10

3. Tertiary Complaint: ____________ When did it start? ______ How often? (% of the day) ______

How did the problem begin? ____________ Getting: Worse/Same/Better

What aggravates problem? ____________ What improves problem? ____________

Rate Pain (0=no pain, 10=excruciating pain): 0 1 2 3 4 5 6 7 8 9 10

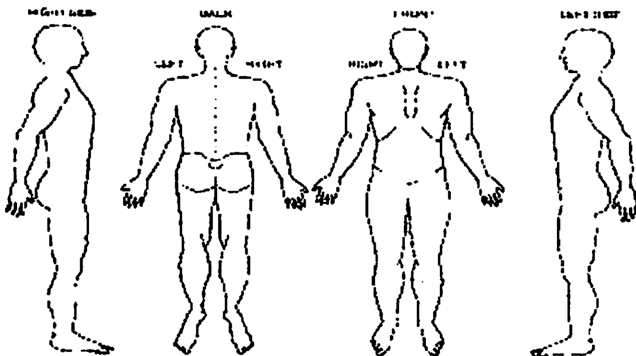
4. Quaternary Complaint: ____________ When did it start? ______ How often? (% of the day) ______

How did the problem begin? ____________ Getting: Worse/Same/Better

What aggravates problem? ____________ What improves problem? ____________

Rate Pain (0=no pain, 10=excruciating pain): 0 1 2 3 4 5 6 7 8 9 10

Indicate on the drawings below where you have pain/symptoms:



Describe the type of pain for each Problem (indicate with problem # 1, 2, 3 and/or 4):

Sharp ______ Shooting ______ Sharp with Motion ______
Dull ______ Stiff ______ Shooting with Motion ______
Diffuse ______ Numb ______ Stabbing with Motion ______
Achy ______ Tingly ______ Electric with Motion ______
Burning ______ Other: ____________

Have you seen: Chiropractor? Y/N Good Result? Y/N
Other Physician/Therapist? Y/N Good Result? Y/N

Patient Signature: ____________ Date: ______/______/______

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Name: Last ______________________ First ______________________ MI ____ Today's Date: ____/____/____

MEDICATIONS (You may attach a list with your name and date at the top for any of the categories below) NONE

Date Started (approx.): __________________ Brand Name: ______________________________ Active Prescription? Y/N
Date Started (approx.): __________________ Brand Name: ______________________________ Active Prescription? Y/N
Date Started (approx.): __________________ Brand Name: ______________________________ Active Prescription? Y/N
Date Started (approx.): __________________ Brand Name: ______________________________ Active Prescription? Y/N
Date Started (approx.): __________________ Brand Name: ______________________________ Active Prescription? Y/N

ALLERGIES NONE

Allergy: ______________________________ Reaction: Hives/Rash/Respiratory/Other: ______________________________
Allergy: ______________________________ Reaction: Hives/Rash/Respiratory/Other: ______________________________
Allergy: ______________________________ Reaction: Hives/Rash/Respiratory/Other: ______________________________

SURGERIES NONE

Date of Surgery (approx.): ______________ Type of Surgery: ____________________ Results: ____________________
Date of Surgery (approx.): ______________ Type of Surgery: ____________________ Results: ____________________
Date of Surgery (approx.): ______________ Type of Surgery: ____________________ Results: ____________________
Date of Surgery (approx.): ______________ Type of Surgery: ____________________ Results: ____________________

HOSPITALIZATIONS NONE

Date of Hospitalization (approx.): ________ Reason: ______________________ Hospital: ____________________
Date of Hospitalization (approx.): ________ Reason: ______________________ Hospital: ____________________
Date of Hospitalization (approx.): ________ Reason: ______________________ Hospital: ____________________

MAJOR ILLNESS NONE

Date of Illness (approx..): ______________ Type of Illness: ______________________________________
Date of Illness (approx..): ______________ Type of Illness: ______________________________________

TESTS (Imaging such as X-ray/CT scan/MRI/NCV, etc.) (You may attach a copy of the test results) NONE

Date of Test (approx.): __________ Type of Test: __________________ Results: __________________ POS/NEG
Date of Test (approx.): __________ Type of Test: __________________ Results: __________________ POS/NEG
Date of Test (approx.): __________ Type of Test: __________________ Results: __________________ POS/NEG

FAMILY HISTORY

Have your family members suffered from:

Cancer:	NO	YES: Relationship: ______________	Deceased? Y/N	Cause of Death ____________
Diabetes:	NO	YES: Relationship: ______________	Deceased? Y/N	Cause of Death ____________
Heart Disease:	NO	YES: Relationship: ______________	Deceased? Y/N	Cause of Death ____________
Heart Failure:	NO	YES: Relationship: ______________	Deceased? Y/N	Cause of Death ____________
High Blood Pressure:	NO	YES: Relationship: ______________	Deceased? Y/N	Cause of Death ____________
Kidney Disease:	NO	YES: Relationship: ______________	Deceased? Y/N	Cause of Death ____________
Stroke:	NO	YES: Relationship: ______________	Deceased? Y/N	Cause of Death ____________

SOCIAL HISTORY

Smoker: No/Former Smoker/Current Everyday/Current Some Days
Alcohol: None/Casual/Moderate/Heavy
Caffeine: None/Less than 3 drinks per day/3-6 drinks per day/More than 6 drinks per day
Drug Use: None/Recreational/Addiction
Exercise: None/Daily/Weekly/Walks/Runs/Other: ____

FOR NECK PAIN, FILL OUT ATTACHED "NECK DISABILITY INDEX" Not Applicable
FOR LOW BACK PAIN FILL OUT ATTCHED "REVISED OSWESTRY DISABILITY' Not Applicable

Patient Signature: ____ **Date:** ____/____/____

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Patient Name: ______________________________ Today's Date: ______________________

Please mark each activity below that is effected by your current condition. Also, mark for each activity affected, the level of limitation that is most closely associated with your condition.

Activities	Limitations		
Bending Over	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Caring for Family	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Climbing Stairs	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Concentrating	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Dressing Self	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Driving Car	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Exercising	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Getting In/Out of Car	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Getting to Sleep	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Grocery Shopping	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Performing Household Chores	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Lifting Objects	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Looking Over Shoulder	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Making Love	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Lying Down	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Reaching Overhead	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Rising Out of Chair or Bed	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Showering or Bathing	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Sitting	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Standing	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Staying Asleep	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Using a Computer	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Walking	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Participating in Yard Work	☐ Painful but can do	☐ Painful with limitations	☐ Unable to do because of pain
Other (please explain) ______________________________			

Patient Signature: ______________________________ Today's Date: ______________________

Patient History and Review of Systems Questionnaire

Adjust Chiropractic

** Please circle **C** for **current**, **P** for **past**, and **N** for **never**

Musculoskeletal

TMJ	C	P	N
Headaches	C	P	N
Neck Pain	C	P	N
Upper Back Pain	C	P	N
Mid Back Pain	C	P	N
Low Back Pain	C	P	N
Pelvic/Tailbone Pain	C	P	N
Shoulder Pain	C	P	N
Elbow/Arm Pain	C	P	N
Wrist/Hand Pain	C	P	N
Hip Pain	C	P	N
Knee Pain	C	P	N
Ankle/Foot Pain	C	P	N
Numbness/Tingling Arms, Hands, or Fingers	C	P	N
			N
Numbness/Tingling Legs, Feet, and Toes	C	P	N
			N
Scoliosis	C	P	N
Fractures	C	P	N
Arthritis	C	P	N
Stiffness	C	P	N
Joint swelling	C	P	N
Muscle Weakness/Loss of Strength	C	P	N
			N
Muscle Cramps	C	P	N
Muscle Aches	C	P	N
Herniated/Bulge Disc	C	P	N
Osteoporosis	C	P	N
Gout	C	P	N

Neurological

Migraines	C	P	N
Numbness/Tingling	C	P	N
Weakness	C	P	N
Difficulty Concentrating	C	P	N
Confusion	C	P	N
Memory Loss	C	P	N
Dizziness	C	P	N
Room Spinning Sensation	C	P	N
Poor Balance	C	P	N
Falling Down	C	P	N
Coordination Difficulty	C	P	N
Fainting	C	P	N
Delayed Motor Skills	C	P	N
Speech Delay	C	P	N
Slurred Speech	C	P	N
Inability to Speak	C	P	N
Diabetic Neuropathy	C	P	N

Neurological (cont.)

Visual Disturbances	C	P	N
Brief Paralysis	C	P	N
Seizures/Epilepsy	C	P	N
Narcolepsy	C	P	N
Parkinson's Disease	C	P	N
Alzheimer's Disease	C	P	N

Cardiovascular

Stroke/CVA brain	C	P	N
Blood Clots	C	P	N
Pacemaker	C	P	N
High Cholesterol	C	P	N
High Blood Pressure	C	P	N
Low Blood Pressure	C	P	N
Heart Disease	C	P	N
Heart Murmur	C	P	N
Angina	C	P	N
Shortness of breath lying down flat	C	P	N
			N
Shortness of breath with exertion	C	P	N
			N
Difficulty breathing at night	C	P	N
Bluish Color Lip/Nails	C	P	N
Lightheadedness	C	P	N
Fatigue	C	P	N
Chest Pain or Discomfort	C	P	N
Irregular or Rapid Heartbeat	C	P	N
Leg cramps with exertion	C	P	N
Swelling Feet/Ankles	C	P	N
Congenital Anomaly	C	P	N

Endocrine

Excessive thirst	C	P	N
Excessive hunger	C	P	N
Excessive urination	C	P	N
Cold intolerance	C	P	N
Heat intolerance	C	P	N
Fatigue	C	P	N
Hyperactivity	C	P	N
Weight Changes	C	P	N
Goiters	C	P	N
Thyroid Cancer	C	P	N
Thyroid Disorders	C	P	N
Excessive Appetite	C	P	N
Growth Disorders	C	P	N

Gastrointestinal

Loss of Appetite	C	P	N

Gastrointestinal (cont.)

Heartburn/Indigestion	C	P	N
Nausea/Vomiting	C	P	N
Vomiting Blood	C	P	N
Reflux/GERD	C	P	N
Hiatal Hernia	C	P	N
Abdominal Pain	C	P	N
Abdominal Bloating	C	P	N
Excessive Gas	C	P	N
Yellow Skin Color	C	P	N
Change in Bowel Habits	C	P	N
Dark, Tarry Stools	C	P	N
Bright Red Blood in Stool	C	P	N
Constipation	C	P	N
Diarrhea	C	P	N
Hernias	C	P	N
Ulcers	C	P	N
Appendicitis	C	P	N
Esophagitis	C	P	N
Pancreatitis	C	P	N
Pancreatic Cancer	C	P	N
Diabetes Mellitus Type II	C	P	N
Diverticulitis	C	P	N
Diverticulitis	C	P	N
Chron's Disease	C	P	N
Irritable Bowel Syndrome	C	P	N
Other Bowel Disease	C	P	N
Colon Cancer	C	P	N
Hemorrhoids	C	P	N
Anal Itch	C	P	N
Rectal/Anal Cancer	C	P	N

Allergies/Autoimmune/ Immunological

Seasonal Allergies	C	P	N
Food Allergies	C	P	N
Allergies to Medications	C	P	N
Other Allergies	C	P	N
Hives	C	P	N
Allergy Shots	C	P	N
Tremors	C	P	N
Type I Diabetes Mellitus	C	P	N
Alopecia Areata	C	P	N
Psoriasis	C	P	N
Rheumatoid Arthritis	C	P	N
Multiple Sclerosis	C	P	N
Systemic Lupus	C	P	N
Erythematosus	C	P	N
Inflammatory Bowel Disease	C	P	N

Allergies/Autoimmune/ Immunological

Addison's Disease	C	P	N
Grave's Disease	C	P	N
Sjogren's Syndrome	C	P	N
Hashimoto's Thyroiditis	C	P	N
Myasthenia Gravis	C	P	N
Autoimmune Vasculitis	C	P	N
Pernicious Anemia	C	P	N
Celiac's Disease	C	P	N
Polymyalgia Rheumatica	C	P	N

Hepatobiliary

Gallstones	C	P	N
Gallbladder problems	C	P	N
Hepatitis A	C	P	N
Hepatitis B	C	P	N
Hepatitis C	C	P	N
Liver Disease	C	P	N
Liver Cancer	C	P	N

Dermatological

Mole (increased size)	C	P	N
Mole (change in color)	C	P	N
Skin Discoloration	C	P	N
Eczema	C	P	N
Psoriasis	C	P	N
Increased Dryness of Skin	C	P	N
Itching	C	P	N
Hives	C	P	N
Rash	C	P	N
Blisters	C	P	N
Suspicious Lesions	C	P	N
Skin Cancer	C	P	N
Age Spots	C	P	N
Changes in Nail Beds	C	P	N
Flushing	C	P	N
Poor Wound Healing	C	P	N
Night Sweats	C	P	N
Excessive Perspiration	C	P	N
Hair Loss/Alopecia	C	P	N
Unusual Hair Distribution	C	P	N

Respiratory

Wheezing	C	P	N
Asthma	C	P	N
Bronchitis	C	P	N
Pneumonia	C	P	N
Shortness of Breath	C	P	N
Cough	C	P	N
Coughing up blood	C	P	N
Excessive Sputum	C	P	N
Excessive Snoring	C	P	N

Respiratory (cont.)

Sleep Apnea	C	P	N
Chest Discomfort	C	P	N
Lung/Respiratory Disease	C	P	N
Emphysema	C	P	N
Lung Cancer	C	P	N
Cystic Fibrosis	C	P	N
Bronchiectasis	C	P	N

Hemato/Lymphatic

Anemia	C	P	N
Sickle Cell Anemia	C	P	N
Lymphoma	C	P	N
Hemophilia	C	P	N
Leukemia	C	P	N
Enlarged Lymph Nodes	C	P	N
Bleed/Bruise easily	C	P	N
Blood Transfusions	C	P	N
HIV Exposure	C	P	N

Eyes

Blurred Vision	C	P	N
Double Vision	C	P	N
Floaters/Flashes/Halos	C	P	N
Light Sensitivity	C	P	N
Dryness/Irritation	C	P	N
Redness	C	P	N
Eye Pain	C	P	N
Eye Discharge	C	P	N
Excessive Tearing	C	P	N
Droopy Eyelid	C	P	N
Vision Loss – Left Eye	C	P	N
Vision Loss – Right Eye	C	P	N
Vision Loss – Both Eyes	C	P	N
Cataracts	C	P	N
Macular Degeneration	C	P	N
Glaucoma	C	P	N
Contacts	C	P	N
Glasses	C	P	N

Ears/Nose/Throat

Ear Infections	C	P	N
Hearing Impairment/Loss	C	P	N
Ear Infections	C	P	N
Ear Discharge	C	P	N
Tinnitus	C	P	N
Nosebleeds	C	P	N
Deviated Septum	C	P	N
Sinus Problems	C	P	N
Hoarseness	C	P	N
Sore Throat or Tonsillitis	C	P	N
Difficulty Swallowing	C	P	N

Renal/Genitourinary

Difficulty/Burning Urination	C	P	N
Urinary Incontinence	C	P	N
Blood in Urine	C	P	N
Urinary Urgency	C	P	N
Inability to Empty Bladder	C	P	N
Wake at Night to Urinate	C	P	N
Sexually Transmitted Disease	C	P	N
Urinary Tract Infection	C	P	N
Bladder Infection	C	P	N
Kidney Infection	C	P	N
Kidney Stones/Pain	C	P	N
Kidney Disease	C	P	N
Kidney Cancer	C	P	N
Lack of Sex Drive	C	P	N

Women Only

Excessively Heavy Period	C	P	N
Missed Periods	C	P	N
Painful Periods	C	P	N
Abnormal Vaginal Bleeding	C	P	N
PMS	C	P	N
Abnormal Vaginal Discharge	C	P	N
Polycystic Ovarian Syndrome	C	P	N
Endometriosis	C	P	N
Pregnancy(s)	C	P	N
Miscarriage(s)	C	P	N
Hot Flashes	C	P	N
Menopause Difficulties	C	P	N
Cervical/Uterine CA	C	P	N

Men Only

Burning Penile Discharge	C	P	N
Erectile Dysfunction	C	P	N
Testicular Pain/Swelling	C	P	N
Testicular Cancer	C	P	N
Benign Prostatic Hyperplasia	C	P	N
Prostate Cancer	C	P	N

Emotional/Mental

ADD/ADHD	C	P	N
Anxiety	C	P	N
Panic Attacks	C	P	N
Depression	C	P	N
Suicidal Thoughts	C	P	N
Suicidal Attempts	C	P	N
Learning Disability	C	P	N
Other Mental Illness	C	P	N

Other

Breast Cancer	C	P	N
Other Medical Illness	C	P	N

Adjust Chiropractic
1258 Washington Road, Thomson, GA 30824
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Patient's Name: ______________________ Today's Date: ______________________

Neck Disability Index Questionnaire

Instructions: This questionnaire has been designed to give your doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section with the ONE answer that applies best to you. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Headaches

- I have no headaches at all.
- I have slight headaches, which come infrequently.
- I have moderate headaches, which come infrequently.
- I have moderate headaches, which come frequently.
- I have severe headaches, which come frequently.
- I have headaches almost all the time.

Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need help every day in most aspects of self-care.
- I need some help every day in most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all because of severe pain in my neck.

Concentration

- I can concentrate fully when I want with no difficulty.
- I can concentrate fully when I want with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want.
- I have a lot of difficulty in concentrating when I want.
- I have a great deal of difficulty in concentrating when I want.
- I cannot concentrate at all.

Work

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Recreation

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I can't do any recreational activities at all.

Patient Signature: ______________________ **Date:** ______________________

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Low Back Disability Index Questionnaire

Instructions: The questionnaire has been designed to give your doctor information as to how your low back pain has affected your ability to manage everyday life. Please answer every section and mark in each section the ONE answer that applies to you best. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much

Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

Sitting

- I can sit in a chair as long as I like without pain.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

Personal Care (Washing, Dressing, etc.)

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing or dressing without help.

Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can only walk while using a cane or on crutches.
- I am in bed most of the time and have to crawl to the toilet.

Standing

- I can stand as long as I want without pain.
- I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than ten minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

Sleeping

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than than one-quarter.
- Because of pain, my normal night's sleep is reduced by less than one-half.
- Because of pain, my normal night's sleep is reduced by less than three-quarters.
- Pain prevents me from sleeping at all.

Traveling

- I get no pain while traveling.
- I get some pain while I travel, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very much.
- I have hardly any social life because of the pain.
- I can't drive my car at all because of the pain.

Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Patient Signature: ______________________________ **Date:** ______________________

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Informed Consent for Treatment

I, the undersigned, a patient in this office, understand that chiropractic treatment does carry certain rare risks. Complications can include, but are not limited to: sprain/strains, irritation of disc conditions, minor fractures, oculosympathetic palsy, dislocations, and cerebrovascular accidents. According to various literature sources, the rate of a cerebrovascular accident (stroke) occurring from a chiropractic adjustment is one per million to one per ten million. I acknowledge that x-rays may be included as part of my examination and treatment program in this office. I realize the ionization from x-ray may pose some risk, especially to an unborn fetus. I accept full responsibility and agree to immediately inform the doctor and staff of Adjust Chiropractic if there is any possibility of pregnancy.

I hereby authorize the doctor(s) and Adjust Chiropractic assistants to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained from my chiropractic treatment. By signing below, I agree that treatment goals and possible complications have been properly conveyed to me and that I hereby consent to treatment. My consent encompasses all techniques and procedures that the doctor(s) of Adjust Chiropractic deems necessary throughout my care in this office.

______________________________	____/____/____
Patient's Printed Name	Today's Date (mo/day/year)
______________________________	______________________________
Patient's Signature	Witness Signature