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

**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

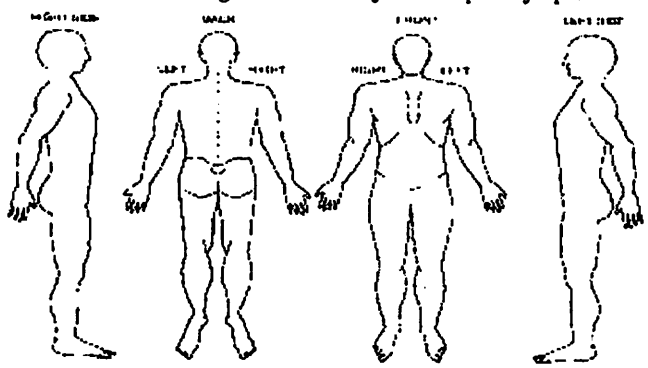
4. Quaternary Complaint: _____ When did it start? _____ How often? (% of the day) _____

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 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 |

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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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Patient's Name: _____ Today's Date: _____

## 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