



## Health Objectives & Clinic Policies

### 1.) Education - To take control of your health:

In order for you to be able to achieve your health goals, our office educates our patients. We also use an online platform, called MoveNow University, to provide a variety of resources and videos that cover health topics and functional exercises to supply the tools you need to achieve those health goals and to transform your life.

### 2.) Scheduling and appointments:

**Our most successful patients are the ones who schedule out, and stick with it.**

- a. In order for you to reserve times that work best for your schedule, **we ask you to schedule out as far in advance as possible (entire 3-4 months is preferred).**
  - i. It is important to remember, that the times that you schedule are times that we are reserving for you, and turning other patients away.
- b. Should you have to change an appointment time, please call us with as much advanced notice as possible. Cancellations made in **less than an hour of the scheduled appointment time** will result in a cancellation fee of **\$20.00** per missed appointment, this includes **no call no show** appointments.
- c. If you **MUST** cancel an appointment, please be prepared to reschedule at that time of cancellation. We ask that you make up this appointment.
- d. If you may be running late to an appointment, please call our office so we can ensure your appointment is still safe. Please understand if we are still able to accommodate your appointment that their might be some extra waiting or all services might not be rendered.
- e. If you have any concerns about your frequency or care, please let the front office know and we will help resolve any issues.

### 3.) Our Mission is to help our patients to achieve a better quality of life:

Please help us spread the word by inviting your friends, family and co-workers with you to an appointment so they can see what we do. This is the best way to help those you know who are suffering!

- I consent to receive email updates about clinic promotions, patient education and all other clinic communications.**

Email: \_\_\_\_\_

I understand the above policies and know that what I put into my health is what I will receive in return.

\_\_\_\_\_  
Patient Signature / Date

\_\_\_\_\_  
ASC Signature / Date

## ALIGN THE SPINE CHIROPRACTIC, LLC

### 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 Align the Spine Chiropractic, LLC 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



Witness Initials

**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



Witness Initials

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

### ACTIVITIES OF LIFE

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

**ACTIVITIES:**

**EFFECT:**

Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Form Reviewed

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

## REVIEW OF SYSTEMS

Please mark: **P** for in the **Past**      **C** for **Currently** have      **N** for **Never**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Prostate Problems        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Heart Problem        |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Colon Trouble            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Diarrhea/Constipation    | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> Menstrual Problem        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression      | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes    | <input type="checkbox"/> Learning Disability      | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers |   | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes     |   | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Trouble Sleeping         | <input type="checkbox"/> Hepatitis (A,B,C)    |

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

# APPLICATION FOR CARE AT ALIGN THE SPINE CHIROPRACTIC, LLC

Today's Date: \_\_\_\_\_

HR#: \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birthdate: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Marital Status:  Single  Married Do you have insurance?  Yes  No

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

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

<b>Primary</b> or chief complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Second</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Third</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
<b>Fourth</b> complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes **If yes**, when? \_\_\_\_\_ by whom? \_\_\_\_\_

How long were you under care? \_\_\_\_\_ What were the results? \_\_\_\_\_

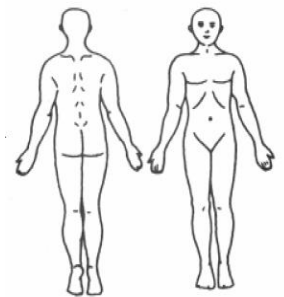
Name of previous chiropractor: \_\_\_\_\_  N/A

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

**R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_



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

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ DATE: \_\_\_\_\_

Is your problem the result of ANY type of accident?  Yes  No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

\_\_\_\_\_  
\_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes**, how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state what type of treatment: \_\_\_\_\_, and who provided it? \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results.  Favorable  Unfavorable Please explain: \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have 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      **N** for **Never** have had

Broken Bone     Dislocations     Tumors     Rheumatoid Arthritis     Fracture     Disability     Cancer  
 Heart Attack     Osteo Arthritis     Diabetes     Cerebral Vascular     Other serious conditions: \_\_\_\_\_

**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 WHOM
<b>INJURIES</b>			
<b>SURGERIES</b>			
<b>CHILDHOOD DISEASES</b>			
<b>ADULT DISEASES</b>			

**FAMILY HISTORY**

1. Does anyone in your family suffer with the same condition(s)?  No  Yes **If yes**, 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

2. Any other hereditary conditions the doctor should be aware of?  No  Yes: \_\_\_\_\_

**SOCIAL HISTORY**

- 1. **Smoking:**  cigars  pipe  cigarettes    How often?  Daily       Weekends       Occasionally       Never
- 2. **Alcoholic Beverage:** consumption occurs       Daily       Weekends       Occasionally       Never
- 3. **Recreational Drug use:**       Daily       Weekends       Occasionally       Never
- 4. **Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect? (See Activities of Life form)

I hereby authorize payment to be made directly to Align the Spine Chiropractic, LLC, 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 Align the Spine Chiropractic, LLC for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

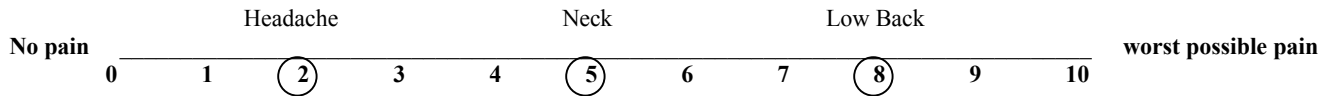
Date \_\_\_\_\_

**Please read carefully:**

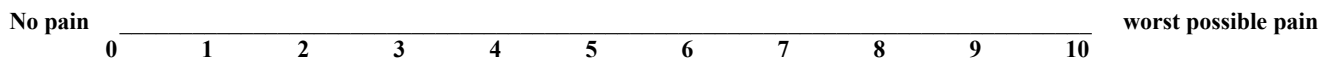
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

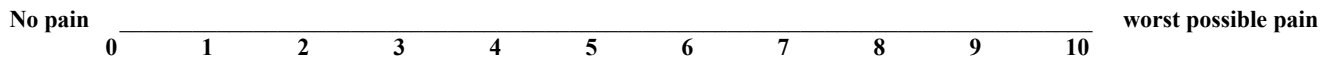
**Example:**



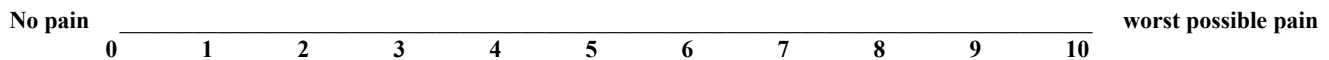
**1 – What is your pain RIGHT NOW?**



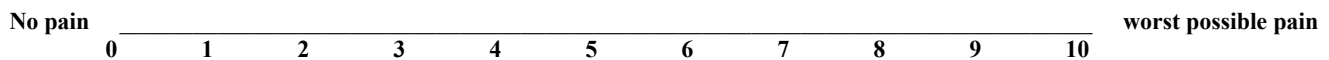
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

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Examiner \_\_\_\_\_

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.