



PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

(This Application will take you between 20 & 30 minutes to fill out. Please fill out and complete prior to your appointment.)

Patient Signature:

Today's Date:

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____
Birth Date: ____/____/____ Social Security #: _____ - _____ - _____ Marital Status: S M D W
Names of Children: _____ Ages: _____
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____
Name of Insurance Co: _____ Policy ID#: _____ Group #: _____
Name on Health Insurance Card: (circle one) self spouse parent Insured's Date of Birth: _____
Are you pregnant or think you may be pregnant? _____ Do you have a pace maker? _____
How were you referred to this office? (circle one) MD/DO referral _____ Patient referral _____
AT&T Yellow Pages Online AT&T Yellow Pages Great Lakes Comm. Directory Newspaper Insurance Directory Insurance Website
Expo Our Website Search Engine (Google/Yahoo) Newsletter Lunch & Learn Other: _____

PURPOSE OF THIS VISIT

Reason for this visit: _____
Is this purpose related to an auto accident/work injury? Yes No If so, when: _____
Describe: _____
Please describe the pain & its location: _____
When did this condition begin? ____/____/____ When did you first notice it? _____
Is this condition getting worse? Yes No Is this condition: Constant Comes & goes Activity related
Does complaint(s) interfere with: __ Work __ Sleep __ Hobbies __ Daily Routine Explain: _____
What activities aggravate your symptoms? _____
Is there anything, which has relieved your symptoms? Yes No If so, please explain: _____
Have you experienced this condition before? Yes No If so, please explain: _____
Who have you seen for this? _____ What did they do? _____
How did you respond? _____
Primary Physician (Facility, Address & Phone Number) _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? _____ When? _____
Have you seen a Pettibon doctor before? Yes No Who? _____ When? _____
Reason for visits: _____
How did you respond? _____
Did your previous chiropractor take before and after x-rays? Yes No
Did you know posture determines your health? Yes No
Are you aware of any of your poor posture habits? Yes No
Explain: _____
Are you aware of any poor posture habits in your spouse or children? Yes No Explain: _____
The most common postural weakness is Forward Head Posture Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

HEALTH LIFESTYLE

Date: _____

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from abnormalities, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

- | | | |
|--------------------------------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/Flue |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking |

Other: _____

THORACIC SPINE (UPPER BACK):

Postural distortions from abnormalities (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

- | | |
|-----------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness Of Breath |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Pain On Deep Inspiration/Expiration |

Other: _____

THORACIC SPINE (MID BACK):

Postural distortions from abnormalities (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

- | | |
|----------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain Into Your Ribs/Chest | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Tired/Irritable after eating or when you haven't eaten for a while |

Other: _____

LUMBAR SPINE (LOW BACK):

Postural distortions from abnormalities in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience...

- | | | |
|--------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Menstrual irregularities/cramping (females) |
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections | Other: _____ |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating | |
| <input type="checkbox"/> Muscle cramps in your legs/feet | | |

Please list any health conditions not mentioned (High Blood Pressure, Diabetes, etc): _____

Please list any medications currently taking and their purpose : _____

Please list all past surgeries: _____

Please list all previous traumas, car accidents, falls, & work or sports injury: _____

Family Health History

Have any of your family members ever been diagnosed with the following:

- | | | | |
|--------------------------------------------|----------------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Scoliosis | | |

Other: _____

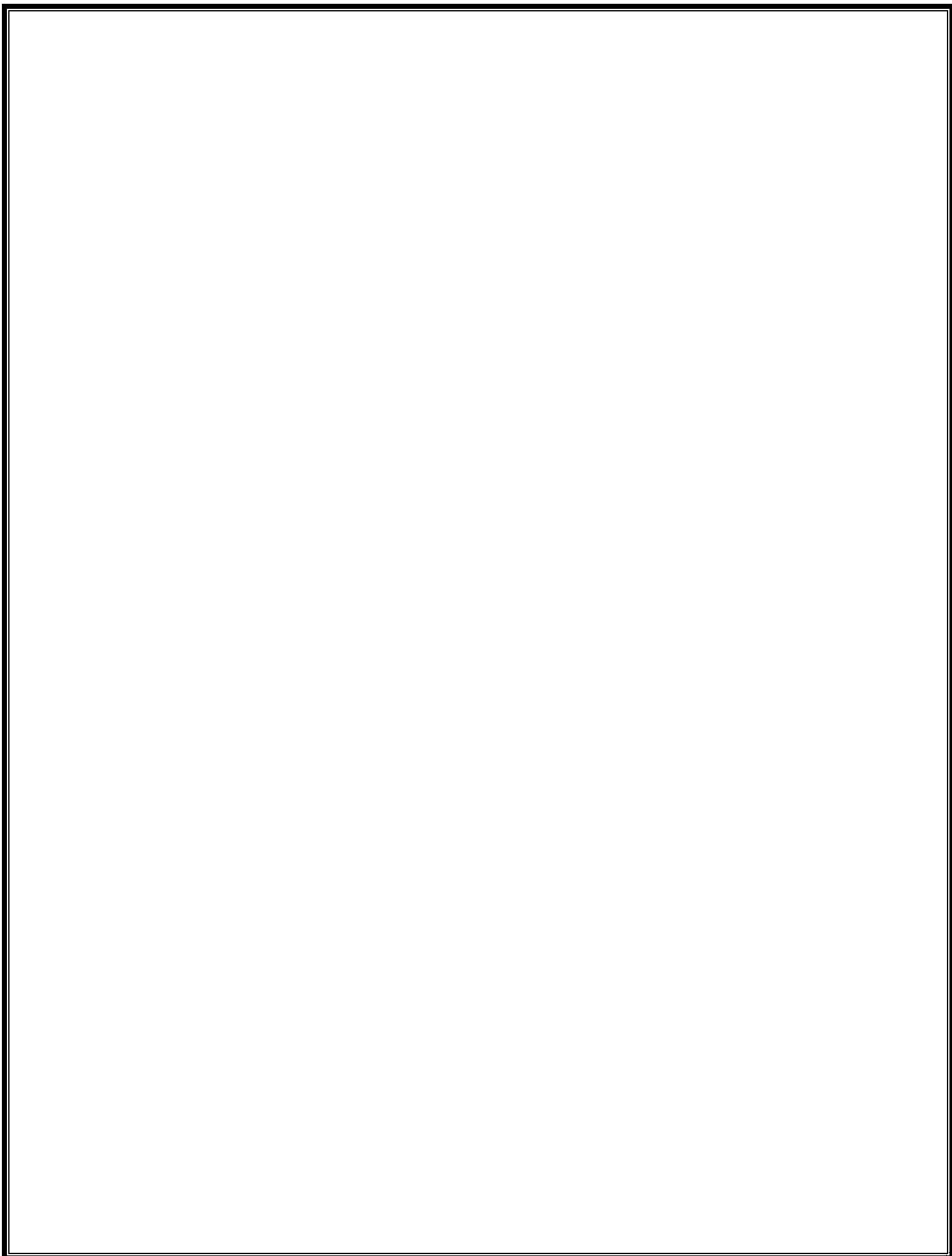
Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. Current Symptom: (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section.)

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Neck <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Upper Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Mid Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Low Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Chest <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Abdomen <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Buttocks <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Upper Arm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p>Other locations: _____</p>	<p>2. 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Does this pain radiate into other body parts?</p> <table border="0" style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Both</td> </tr> <tr> <td><input type="checkbox"/> Head</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Arm</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hand</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hip</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Leg</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Foot</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Other locations of radiation: _____</p>		Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Other types of pain: _____</p> <p>6. Actions affecting this pain</p> <table border="0" style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">Brings On</td> <td style="text-align: center;">Aggravates</td> <td style="text-align: center;">Relieves</td> </tr> <tr> <td><input type="checkbox"/> In the A.M.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> In the P.M.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Bending forward</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> 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II. Current Symptom: (Please check off the boxes below to describe your next symptom. Describe only ONE symptom per section.)

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Front of Head</p> <p><input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Neck <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Upper Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Mid Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Low Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Chest <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Abdomen <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Buttocks <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Upper Arm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p>Other locations: _____</p>	<p>2. 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Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. Current Symptom: (Please check off the boxes below to describe your symptom. **Describe only ONE symptom per section.**)

1. Check only one body location below **2. Types of pain**

Other types of pain: _____

- Headaches L R B
- Front of Head
- Top of Head
- Back of Head

- Dull Sharp Aching Cutting
- Throbbing Burning Numbing Tingling Cramping _____
- Spasm Stinging Shooting Pounding Constricting

- Jaw L R B
- Eye L R B
- Neck L R B
- Upper Back L R B
- Mid Back L R B
- Low Back L R B
- Chest L R B
- Abdomen L R B
- Ribs L R B
- Buttocks L R B
- Shoulder L R B
- Upper Arm L R B
- Forearm L R B
- Hand L R B
- Hip L R B
- Leg L R B
- Foot L R B

Other locations: _____

- 3. Pain Frequency**
- Up to 1/4 of awake time 1/4 to 1/2 of time
 - 1/2 to 3/4 of awake time Most all the time

- 4. Pain Intensity** (How it affects daily activities)
- Doesn't affect Somewhat affects
 - Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|------------------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In the P.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Straining | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Actions: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

II. Current Symptom: (Please check off the boxes below to describe your next symptom. **Describe only ONE symptom per section.**)

1. Check only one body location below **2. Types of pain**

Other types of pain: _____

- Headaches L R B
- Front of Head
- Top of Head
- Back of Head

- Dull Sharp Aching Cutting
- Throbbing Burning Numbing Tingling Cramping _____
- Spasm Stinging Shooting Pounding Constricting

- Jaw L R B
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- Shoulder L R B
- Upper Arm L R B
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- Hand L R B
- Hip L R B
- Leg L R B
- Foot L R B

Other locations: _____

- 3. Pain Frequency**
- Up to 1/4 of awake time 1/4 to 1/2 of time
 - 1/2 to 3/4 of awake time Most all the time

- 4. Pain Intensity** (How it affects daily activities)
- Doesn't affect Somewhat affects
 - Seriously affects Prevents activities

5. Does this pain radiate into other body parts?

- | | Left | Right | Both |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Leg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other locations of radiation: _____

6. Actions affecting this pain

- | | Brings On | Aggravates | Relieves |
|------------------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> In the A.M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> Bending back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bending right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting left | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Twisting right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Actions: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Have you had any of the following:

- Persistent Cough over one month or blood tinged saliva
- Unexplained weight loss, fever, or night sweats
- Change in urinary habits or blood in urine
- Persistent lumps, especially in the breast or testicles
- Blood in the stool or any change in bowel habits
- Non-healing sores
- Obvious change in a wart or mole

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it all, because of the pain". **Only fill in areas affected.**

Difficulties with Self Care and Personal Hygiene Activities

- Bathing____ Drying hair____ Brushing teeth____ Putting on shoes____ Preparing meals____ Taking out trash____
- Showering____ Combing hair____ Making bed____ Tying shoes____ Eating____ Doing laundry____
- Washing hair____ Washing face____ Putting on shirt____ Putting on pants____ Cleaning dishes____ Going to toilet____

Difficulties with Physical Activities

- Standing____ Walking____ Kneeling____ Bending back____ Twisting left____ Leaning back____
- Sitting____ Stooping____ Reaching____ Bending left____ Twisting right____ Leaning left____
- Reclining____ Squatting____ Bending forward____ Bending right____ Leaning forward____ Leaning right____
- Standing for long periods____ Sitting for long periods____ Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities

- Carrying small objects____ Lifting weights off floor____ Pushing things while seated____ Exercising upper body____
- Carrying large objects____ Lifting weights off table____ Pushing things while standing____ Exercising lower body____
- Carrying brief case____ Climbing stairs____ Pulling things while seated____ Exercising arms____
- Carrying large purse____ Climbing inclines____ Pulling things while standing____ Exercising legs____

Difficulties with Social and Recreational Activities

- Bowling____ Jogging____ Swimming____ Ice Skating____ Competitive Sports____ Dating____
- Golfing____ Dancing____ Skiing____ Roller Skating____ Hobbies____ Dining out____

Difficulties with Travelling

- Driving a motor vehicle____ Riding as a passenger in a motor vehicle____ Riding as a passenger on a train____
- Driving for long periods of time____ Riding as a passenger on an airplane____ Riding as a passenger for long periods____

Use the following **1 to 5** scale to describe the difficulties below:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

- Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

- Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

- Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

- Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
- My current complaints DID exist before, but had not been bothering me.
- My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occurred _____
Write in below any other Prior Symptom History, not covered above:

Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
 - My history HAS NOT contributed to my current symptoms.
 - I'm NOT SURE if my history has contributed to my current symptoms.
- _____ months ago / _____ years ago **OR on** Date: ____/____/____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. At Grand Rapids Spine & Posture Center we have one main goal, to detect and correct/reduce health challenges. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of postural abnormality. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Postural Abnormality: A misalignment of one or more regions of the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat a disease or condition other than Postural abnormality. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct postural abnormality combined with rehabilitation procedures. I understand and accept that results are not promised and not guaranteed.

CONSENT TO CARE

I do hereby authorize the doctor of the Grand Rapids Spine & Posture Center to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time and all discounts/promotions are null and void and the regular price charges will be due. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature _____ Date _____ *(If under age 18) Parent's signature*

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctor's office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Signature _____ Date _____ *(If under age 18) Parent's signature*

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Lisa M. Smith of D.C, LLC's of Grand Rapids Spine & Posture Center "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lisa M. Smith of D.C, LLC. The Notice of Privacy Practices for Lisa M. Smith of D.C, LLC is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and our clinic's duties with respect to my protected health information.

Lisa M. Smith of D.C, LLC of Grand Rapids Spine & Posture Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

OUTCOMES ASSESSMENT

DATE: _____

NAME: _____

PLEASE RATE YOUR PAIN FROM 0 TO 10 (10 BEING THE HIGHEST POSSIBLE LEVEL OF PAIN)

OVERALL CONDITION	0	1	2	3	4	5	6	7	8	9	10
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HEADACHES	0 1 2 3 4 5 6 7 8 9 10				
		NECK			
TMJ	0 1 2 3 4 5 6 7 8 9 10	MID BACK	0 1 2 3 4 5 6 7 8 9 10		
CHEST	0 1 2 3 4 5 6 7 8 9 10	LOW BACK	0 1 2 3 4 5 6 7 8 9 10		
ABDOMEN	0 1 2 3 4 5 6 7 8 9 10				

UPPER EXTREMITIES

	RIGHT	LEFT
SHOULDERS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
FOREARMS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
ELBOWS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
ARMS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
WRISTS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
HANDS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
FINGER	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

LOWER EXTREMITIES

	RIGHT	LEFT
HIPS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
THIGHS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
KNEES	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
SHINS	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
ANKLES	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
FEET	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
TOES	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10