

Date \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Initial \_\_\_\_\_

**Major Complaint Information**

What is your major complaint(s)? \_\_\_\_\_

When did this symptom(s) begin? \_\_\_\_\_

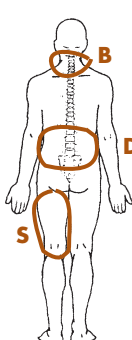
If this is an injury, describe what happened: \_\_\_\_\_

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.

**0 = None**  
**1 = Minimal**  
**2 = Very Mild**  
**3 = Mild**  
**4 = Mild to Moderate**  
**5 = Moderate**  
**6 = Moderate to Severe**  
**7 = Moderately Severe, Restricts some activity**  
**8 = Severe, Limits most activity**  
**9 = Very Severe**  
**10 = Excruciating**

**Pain Index**

**D** Dull Nagging Ache  
**B** Burning  
**S** Sharp / Stabbing  
**N** Numbness / Tingling



*For example: The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.*

**SEVERITY**

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain imaginable, use the key to the right to rate the severity of your pain.

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before?  Yes  No

When? \_\_\_\_\_

What aggravates this condition? \_\_\_\_\_

What decreases the symptoms / pain? \_\_\_\_\_

**Key**

**0 = None**  
**1 = Minimal**  
**2 = Very Mild**  
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**4 = Mild to Moderate**  
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Have you seen another doctor for this condition?  Yes  No Doctor's Name: \_\_\_\_\_

Date consulted: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Does this condition interfere with your sleep?  Yes  No If so, how many times do you wake up in pain per night? \_\_\_\_\_

In what position do you sleep?  Back  Side  Stomach

Do you sleep with a pillow?  Yes  No How many? \_\_\_\_\_

Does heat affect the pain?  Yes  No If so, how? \_\_\_\_\_

Does cold affect the pain?  Yes  No If so, how? \_\_\_\_\_

Do you wear a heel lift?  Yes  No If so, which side?  Right  Left

Does it cause pain to cough, grunt, or sneeze?  Yes  No If so, where? \_\_\_\_\_

### Check those activities below during which you experience difficulty or pain:

- |   |   |                                |  |   |
|---|---|--------------------------------|--|---|
| <input type="radio"/> Lying on back         | <input type="radio"/> Getting in/out of car | <input type="radio"/> Pulling  | <input type="radio"/> Sitting          | <input type="radio"/> Standing for long periods |
| <input type="radio"/> Lying on side         | <input type="radio"/> Dressing Self         | <input type="radio"/> Reaching | <input type="radio"/> Bending forward  | <input type="radio"/> Sneezing                  |
| <input type="radio"/> Turning over in bed   | <input type="radio"/> Sexual Activity       | <input type="radio"/> Kneeling | <input type="radio"/> Bending backward | <input type="radio"/> Coughing                  |
| <input type="radio"/> Lying flat on stomach | <input type="radio"/> Pushing               | <input type="radio"/> Stooping | <input type="radio"/> Walking          | <input type="radio"/> Other: _____              |

### FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

#### Lower Back Pain

Does pain radiate into the leg?  Yes  No Where: \_\_\_\_\_ Does pain radiate to the abdomen?  Yes  No

Do you ever have impairment of bowel or urinary function?  Yes  No Explain: \_\_\_\_\_

Do you have numbness or tingling into the legs?  Yes  No Explain: \_\_\_\_\_

#### Neck Pain

If you have a neck injury, does it affect: (Check all that apply)  Hearing  Vision  Balance  Cause ringing in your ears

Do you hear grating sounds?  Yes  No Do you feel pressure or pain behind your eyes?  Yes  No

Does pain radiate into the arm?  Yes  No Where: \_\_\_\_\_

Do you have difficulty lifting or turning your head?  Yes  No If so, in which direction?  Right  Left  Up  Down

#### Headaches

Do you get headaches?  Yes  No Frequency \_\_\_\_\_ Do you have a family history of headaches?  Yes  No

Do you experience the following along with your headaches: Pain or cracking in your jaw?  Yes  No

Abnormal blood pressure?  Yes  No  High  Low Nausea, Vomiting or Visual disturbances?  Yes  No

When was your last eye exam by a doctor?  1 - 6 months  6 - 12 months  1 - 2 years  over 2 years Results: \_\_\_\_\_

If female, are you pregnant?  Yes  No  Not Sure If no or not sure, date of your last menstrual period: \_\_\_\_\_

List all medications you are taking now, including over the counter medication. \_\_\_\_\_

Are you allergic to any medications?  Yes  No  Not Sure Please list: \_\_\_\_\_

Have you ever had any surgeries or hospitalizations?  Yes  No Please list:

Type of Hospitalization/Surgery: \_\_\_\_\_ Date: \_\_\_\_\_ Type of Hospitalization/Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_

Have you been x-rayed or received MRI, CAT scan in the last 12-18 months?  Yes  No When?: \_\_\_\_\_

Have you ever been seen by a chiropractor before?  Yes  No Please list:

Name of Chiropractor: \_\_\_\_\_ Dates: \_\_\_\_\_ Name of Chiropractor: \_\_\_\_\_ Dates: \_\_\_\_\_  
\_\_\_\_\_

Do you have a family physician?  Yes  No Name of physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

### Additional Complaints

Please check all additional complaints that you have at this time:

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="radio"/> Loss of Concentration   | <input type="radio"/> Neck Stiffness              | <input type="radio"/> Shortness of Breath | <input type="radio"/> Cold Hands              | <input type="radio"/> Heart Disease       |
| <input type="radio"/> Eyes Sensitive to Light | <input type="radio"/> Neck Motion Restricted      | <input type="radio"/> Irritable           | <input type="radio"/> Cold Feet               | <input type="radio"/> Arthritis           |
| <input type="radio"/> Memory Loss             | <input type="radio"/> Upper Back Pain / Stiffness | <input type="radio"/> Anxiety             | <input type="radio"/> Jaw pain                | <input type="radio"/> HIV (Aids)          |
| <input type="radio"/> Heavy Feeling of Head   | <input type="radio"/> Mid Back Pain / Stiffness   | <input type="radio"/> Depression          | <input type="radio"/> Hypertension            | <input type="radio"/> Other (Please List) |
| <input type="radio"/> Dizziness               | <input type="radio"/> Right / Left Shoulder Pain  | <input type="radio"/> Insomnia            | <input type="radio"/> Diabetes                | _____                                     |
| <input type="radio"/> Ringing in Ears         | <input type="radio"/> Right / Left Arm Pain       | <input type="radio"/> Fatigue             | <input type="radio"/> Convulsions             | _____                                     |
| <input type="radio"/> Loss of Balance         | <input type="radio"/> Pins & Needles Arms / Legs  | <input type="radio"/> Excess Perspiration | <input type="radio"/> Allergies (Please List) | _____                                     |
| <input type="radio"/> Loss of Smell           | <input type="radio"/> Right / Left Leg Pain       | <input type="radio"/> Digestive Trouble   | _____   | Please Specify Location:                  |
| <input type="radio"/> Loss of Taste           | <input type="radio"/> Low Back Pain/Stiffness     | <input type="radio"/> Nausea              | _____   | <input type="radio"/> Numbness _____      |
| <input type="radio"/> Pain Behind Eyes        | <input type="radio"/> Sinus Trouble               | <input type="radio"/> Vomiting            | _____   | <input type="radio"/> Swelling _____      |
| <input type="radio"/> Fainting                | <input type="radio"/> Nervousness                 | <input type="radio"/> Diarrhea            | <input type="radio"/> Vision Problems         | <input type="radio"/> Cuts _____          |
| <input type="radio"/> Palpitation             | <input type="radio"/> Chest Pain                  | <input type="radio"/> Constipation        | <input type="radio"/> Anemia                  | <input type="radio"/> Bruising _____      |

Do you have, or have you ever had, any diseases or medical problems not listed?  Yes  No If so, please list: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had?  Motor Vehicle Injury  Sports Injury  Work Injury  Slip and Fall Injury

If yes, please explain: \_\_\_\_\_

Is there any additional information you would like the doctor to know about before beginning care? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

### Areas of Interest

Please mark areas of interest or if you desire more information:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Nutritional Supplements | <input type="checkbox"/> Neck/Body Pillows | <input type="checkbox"/> Ear infection/colic/ADD |
| <input type="checkbox"/> Detoxification          | <input type="checkbox"/> Decompression     | <input type="checkbox"/> Massage                 |
| <input type="checkbox"/> Headaches               | <input type="checkbox"/> Acupuncture       | <input type="checkbox"/> Others (list)           |
| <input type="checkbox"/> Weight Loss Information | <input type="checkbox"/> Wellness Care     | _____  |
| <input type="checkbox"/> Women's Health          | <input type="checkbox"/> Children's Care   | _____  |

## Personal Information

Address: \_\_\_\_\_  
City / State / Zip: \_\_\_\_\_  
Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_  
Mobile Phone: (    ) \_\_\_\_\_ Email: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
City / State / Zip: \_\_\_\_\_  
Marital Status:  S  M  D  W Spouse's Name: \_\_\_\_\_ # of Children: \_\_\_\_\_  
Children's information: \_\_\_\_\_  
How were you referred to Kuzma Chiropractic? \_\_\_\_\_  
\_\_\_\_\_

## Authorization & Assignment

I authorize Kuzma Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Kuzma Chiropractic authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_

## Informed Consent

I hereby authorize physicians and staff at Kuzma Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Kuzma Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

### Specific Risk Possibilities Associated with Chiropractic Care:

**Soreness** - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

**Soft Tissue Injury** - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

**Rib Injury** - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

**Physical Therapy Burns** - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

**Stroke** - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

**Other Problems** - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_