Aligned Chiropractic & Decompression Center
Patient Information Form

Name: _____ Date of Birth: _____Sex:_____

Address: _____City:_____State:_____Zip:_____

Cell Number: (____)_____Work: (____)_____Home(____)_____

Email Address: _____

Occupation: _____ Employer: _____

Single: _____ Married: _____

Policy Holder: _____Policy Holder's Date of Birth: _____

Have you seen a Chiropractor before? **Yes** **No** If Yes, when? _____

Whom may we thank for referring you to our office? _____

Your Health Summary

Please ✓ check all symptoms you have had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins/Needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins/Needles in arms	☐ Loss of Smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Upset stomach
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping Problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold Sweats	☐ Light sensitivity	☐ Problems urinating	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual irregularity	☐ Ulcers

Medications:_____
_____

This office conforms to the current HIPPA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature_____ Date_____

Guardian Signature_____Date_____

Functional Rating Index

For use with neck and/or back problems only.
In order to properly asses your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please **circle** the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain No Restrictions	Mild pain No restricitons	Moderate Need to go slowly	Moderate pain;need some help	Severe pain;need 100% help

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain	Intermittent pain	Frequent pain	Constant pain

8. Lifting

No pain	Increased pain w/ heavy weight	Increased pain w/ moderate weight	Increased pain w/ light weight	Increased pain w/ any weight

9. Walking

No pain	Increased pain after 1 mile	Increased pain after 0.5 miles	Increased pain after 0.25 miles	Increased pain with any walking

10. Standing

No pain	Increase pain after several hours	Increased pain after 1 hour	Increased pain after 30 mins.	Increased pain after any standing

Name_____Date_____

Signature_____ Date_____