HealthSource®
Chiropractic & Progressive Wellness®
Nutritional Medicine • Acupuncture • Massage Therapy

PATIENT INFORMATION 101614

Name:			Date:
Address:			SS #
City:		State:	Zip Code:
Phone	Home:	Cell:	
E-mail:		NOTE: E-mail used for internal communications ONLY	
How did you find us / hear about us?			
What is your Primary Complaint?			
Check if: _____Worker's Comp _____ Motor Vehicle Accident _____ Personal Injury			
	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Person responsible for this account:			Insurance / Self-Pay	
Name of person on your health insurance card:				
Your relationship to cardholder:		Their DOB:	SS #:	
In case of Emergency – Contact Name:		Phone No.:		

PATIENT INFORMED CONSENT: I, the undersigned consent to care at this clinic. I hereby request and consent to the performance of chiropractic care, exams, supportive care and x-rays by the Doctor of Chiropractic and support team at HealthSource. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks can include: aggravating and/or temporary increase in symptoms, muscle spasms, fractures, disc 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's judgment, based upon the facts known. I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach and hopes to avoid more invasive procedures.

I have read, or have had read to me, the above Consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedure.

Patient Signature: _____ _____ _____

HSHealthSource®
Chiropractic & Progressive Wellness®

HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____
Printed Name – Patient or Representative

_____
Signature Date

Relationship to Patient
(if other than patient) _____

Witness: _____
Printed Name – Clinic Representative

_____
Signature Date

For Internal Use:

☐ Patient Refused to Sign ☐ Patient unable to sign for the following reason:_____

HealthSource of Palos Hills
Acupuncture New Patient Questionnaire

Patient_____ Date:_____ Age_____ M or F

Please answer the following questions to the best of your ability.

What is the reason(s) for your visit? Ex. Low back pain, sinus congestion, infertility, etc.

_____
_____
_____
_____
_____

Describe the history of your condition(s). When it began, progression, previous treatments**.**

_____
_____
_____
_____
_____
_____

List any surgeries and medical procedures you have had in the past or are scheduled to have in the future.

_____
_____
_____
_____
_____

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for Taking	Taking Since

Please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc):

Name	Dosage	Reason for Taking	Taking Since

List any allergies or food sensitivities: _____

_____

SYMPTOM SURVEY

Please review the following symptoms and mark an X in the appropriate column.

	In past	Present		In past	Present
Cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in work or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
Sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
Irritability			hearing impairment		
bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			decreased sex drive		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			foggy headed		
afternoon fevers			night sweats		

SYMPTOMS (Cont'd)

	In past	Present		In past	Present
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
change in weight			numbness/tingling		
nose bleeds			pain on urination		
ear aches or infections			athlete's foot		

HEALTH HISTORY

Please indicate any significant illness you or a blood relative (grandparent, parent, sibling) have had:

	You	Which Relative?		You	Which Relative?
Cancer			Diabetes		
Emotional Disorders			Heart Disease		
High Blood Pressure			Seizures		
Rheumatic Fever			Hepatitis		
Arthritis			Tuberculosis		

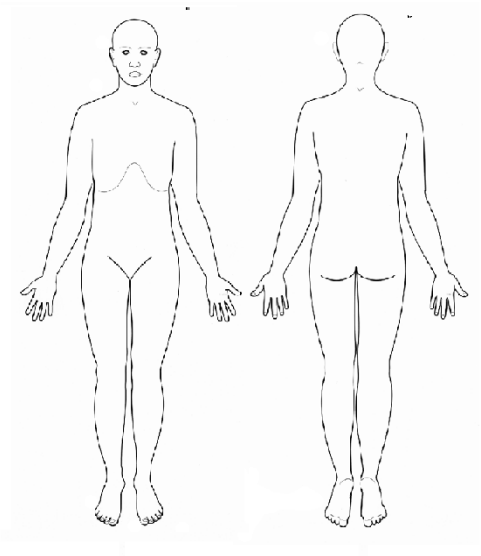
Do you have a bowel movement every day? Yes No _____

Number of bowel movements per day? _____

Are your bowel movements (check all that apply):

- ☐ Well formed
- ☐ Soft
- ☐ Ribbon-like
- ☐ Loose
- ☐ Containing undigested food
- ☐ Containing blood
- ☐ Bad smelling
- ☐ Burning
- ☐ Burning/heaviness in rectum
- ☐ Incomplete
- ☐ Hard to clean up after
- ☐ A struggle

Using the appropriate letters, note any areas of pain on the diagram:



D = Dull
S = Sharp
N = Numbness
T = Tingling
B = Burning
R = Radiating
A = Ache
X = other: _____

Do you have a pacemaker? Yes _____ No _____

Are there any issues of physical / sexual / emotional abuse that you would like to discuss? Yes _____ No _____

LIFESTYLE HISTORY

Please indicate the use and frequency of the following:

	Now	Past	How Much		Now	Past	How Much
Water				Recreational Drugs			
Soda Pop				Alcohol			
Coffee/Black Tea				Tobacco			

Do you exercise? _____ How many times a week? _____

What type of exercise? _____

Please describe your typical diet:

Breakfast:	
Lunch:	
Dinner:	
Snacks:	

meals per day: _____ Do you eat at regular times each day? _____

Diet (Cont'd)

snacks per day: _____ How often do you eat out (or order in)? _____

I eat the following diet (please circle) vegetarian vegan kosher

Are there other restrictions to your diet? _____

What is your average stress level (*1 is lowest, 10 is highest*)? _____

What is your average energy level (*1 is lowest, 10 is highest*)? _____

At what time of day is your energy typically at its best? _____ At its worst? _____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad
Significant Other	☐	☐	☐	☐	☐
Family Relations	☐	☐	☐	☐	☐
Friendships	☐	☐	☐	☐	☐
Self Image	☐	☐	☐	☐	☐
Sex	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Spirituality	☐	☐	☐	☐	☐

How much change are you willing to/able to make at this time to improve your health? (Please circle)

Minimal **Some** **Complete**

FOR MEN

Date of last prostate exam: _____ PSA results: _____

Prostate exam results / diagnosis: _____

Frequency of urination -- Day Time: _____ Night Time: _____

Color of Urine (please circle): Colorless Light Yellow Dark Yellow Reddish

Urine is cloudy: Yes No Urine has an odor: No Yes like: _____

Please mark an X in the appropriate column if you experience any of the following:

	Seldom	Frequent		Seldom	Frequent
Delayed Urine Stream			Increased Libido		
Dribbling Urine			Decreased Libido		
Urinary Incontinence			Discharge/Sores		
Urinary Retention			Premature Ejaculation		
Testicular Masses			Inability to Ejaculate		
Testicular Pain			Difficulty Achieving Erection		
Groin Pain			Difficulty Sustaining Erection		
Hernia			Impaired Fertility		
Back Pain			Rectal Dysfunction		

Are You Sexually Active? Yes No

List any known STDs: _____

Is there anything else you would like us to know? _____

_____

_____

_____

FOR WOMEN

Date of last OB/GYN exam:: _____ Are you pregnant now? Yes No

Age of first period: _____ Age of last period (post menopause): _____
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Number of days between periods: _____ Number of days of bleeding: _____

The bleeding is: □ Heavy □ Moderate □ Light □ Spotting Only

Menstrual Blood Color (check all that apply): □ Pale Pink / Red □ Red □ Bright Red
□ Dark Red □ Dark Red / Brown □ Black □ Dark Purple

Number of pads/tampons used: ___ day 1 ___ day 2 ___ day 3 ___ day 4 ___ day 5 ___ day 6+

How often do you change your pad/tampon? □ Every hour or less □ Every 2 hours
□ Every 4 hours □ I don't really need to change it, but I do for hygiene
Other:_____

On your heaviest day, which do you use? □ Regular □ Super □ Super Plus

Do you bleed between periods? Yes No

If yes, bleeding is: □ Heavy □ Moderate □ Light □ Spotting Only

Periods are painful: □ Before Period □ During Period □ After Period □ N/A

Pain severity: □ Mild □ Moderate □ Severe □ N/A

Location of pain: □ Low Abdomen □ Low Back □ Thighs □ Other:_____

The quality of the pain is (check all that apply): □ Cramping □ Stabbing □ Aching □ Dull
□ Burning □ Constant □ Comes & Goes □ Bearing Down

Do you pass clots during your period? (please circle) yes no

Clot Color: □ Bright Red □ Dark Red □ Brownish □ Black □ Dark Purple □ Sticky

On average, the clot size is: □ Small & Stringy □ Small & Round □ Dime Sized
□ Egg Yolk Sized □ Larger Than an Egg Yolk

Do you feel pain when you pass the clots? (please circle) Yes No N/A

Do you feel better after passing the clots? (please circle) Yes No N/A

FOR WOMEN (continued)

Please review the following symptoms related to your period and mark an X in the appropriate column.

	Seldom	Frequent		Seldom	Frequent
Headaches			Swollen or Painful Breasts		
Cravings			Mood Swings		
Nausea			Increased Appetite		
Constipation			Decreased Appetite		
Diarrhea			Insomnia		

Have your periods changed since they started? Yes No

When? _____

Why? _____

Total Number of Pregnancies: _____ Number of Live Births: _____

Number of Miscarriages: _____ Number of Terminations: _____

Are You Sexually Active? Yes No

List any known STDs: _____

Current Type of Birth Control: _____ Used for How Long? _____

What other types of birth control have you used in the past? _____

Do you experience any sexual difficulties? (please describe) _____

Please mark an X in the appropriate column if you experience any of the following:

	Seldom	Frequent		Seldom	Frequent
Endometriosis			Fibrocystic Breasts		
Ovarian Cysts			Breast Cancer		
Uterine Fibroids			Breast Lumps		
Abnormal Pap Smear			Nipple Discharge		
Yeast Infections			Vaginal Discharge/Odor		
Urinary Tract Infections			Herpes		
Pain/Itching of Genitalia			HPV (Human Papilloma Virus)		
Genital Lesions/Discharge			Hysterectomy		
PID (Pelvic Inflammatory Disease)			Uterine Prolapse		

Is there anything else you would like us to know? _____

FERTILITY INFORMATION

How long have you been trying to get pregnant? _____

A physician diagnosed fertility difficulty due to: ☐ Female Factor ☐ Male Factor ☐ Unexplained
☐ Other: _____ ☐ Not Diagnosed

OB/GYN Physician or Reproductive Endocrinologist: _____
Physician's Phone: _____

OVULATION INFORMATION

On what cycle day do you ovulate? _____ Do you use an ovulation predictor kit? Yes No

Do you chart your basal body temperature? Yes No

Please check off any symptoms experienced at ovulation:
☐ Sharp Pain ☐ Breast Tenderness ☐ Bowel Movement Changes
☐ Cramping ☐ Irritability / Rage ☐ Other: _____

Describe the quantity of your cervical mucus at ovulation:
- ☐ None, I never notice any even with internal exam
- ☐ Scant, I only notice it with internal exam
- ☐ Moderate, I notice some on my underwear and when I urinate
- ☐ Profuse, I notice large amounts in my underwear and when I urinate

Describe the quality of your cervical mucus at ovulation:
- ☐ Watery ☐ Creamy, Thick
- ☐ Egg White, Stretchy ☐ Like Rubber Cement
- ☐ Other: _____

Cervical mucus at ovulation lasts for how many days? _____

Do you notice cervical mucus at other times during your cycle? Yes No
If yes, when? _____ For how many days? _____

Describe the quality & quantity of that mucus: _____

FERTILITY INFORMATION (continued)

LABORATORY & PHYSICAL EXAM- RESULTS

Hormone Levels:

Estradiol: _____ FSH: _____ LH: _____

Estrogen: _____ Progesterone: _____

Other Blood Test Results: _____

Laparascopy: _____

HSG (Test to Determine State of Fallopian Tubes): _____

Ultrasound : _____

Uterine Abnormalities : _____

FERTILITY TREATMENTS

List any medications taken to enhance fertility: _____

_____

Number of IVF procedures: _____ Number of IUIs: _____

What are your treatment goals related to fertility? _____

_____

_____

Describe the emotions that most closely related to your journey towards pregnancy: _____

_____

_____

Is there anything else you would like us to know? _____

_____

_____

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Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____
PATIENT SIGNATURE INSURED'S SIGNATURE

_____
DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured/Guardian Date