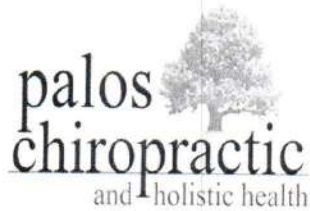


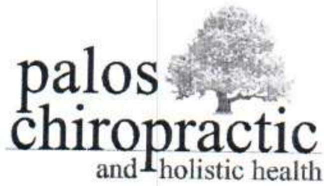
PATIENT INFORMATION 092418

Name:	Date:
Address:	SS #
City:	State:	Zip Code:
Phone Home:	Cell: Cell Phone Carrier: (For Appt. Reminders)
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: ______________________________



Dr. Robert Wright, DC, DCBCN
Chiropractic Physician / Clinical Nutritionist
10059 S. Roberts Road, Palos Hills IL 60465
708.598.9144 www.PalosChiro.com

FINANCIAL AGREEMENT 12122017

- INSURANCE PATIENTS: I understand I am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.
- I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
- I am responsible for updating my health insurance information with the office any time the information changes, terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
- Authorization to Release Information: I hereby authorize the Provider to release any information required to process my claim(s.)

- SELF-PAY PATIENTS: All self-pay patients are required to pay at the end of each visit. No balances past 90 days will remain in the office and will be moved to an outside vendor for collection.

Patient Signature/Date: ______________________________ ____________

Insured Signature/Date: ______________________________ ____________

Signatue of Guardian / Date: ____________________________ ____________

HIPPA PATIENT CONSENT FORM 092418

We are required by the Health Insurance Portability & Accountability Act of 1996 (HIPPA) to maintain the privacy of your protected health information (PHI).

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment and health care operations.

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

____

Printed Name or Patient or Representative

____

Signature / Date

Relationship to Patient (if other than patient): ______________________________

( ) Patient Refused to Sign

( ) Patient unable to sign for the following reason: ____________________

palos chiropractic and holistic health

Nutritional Medicine
Acupuncture
Therapeutic Massage

Palos Hills 708.598.9144 www.PalosChiro.com

NAME: DATE: / / Account#:

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: ______________________________

____

TIMING & DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent _____Occasional

What caused the onset? ______________________________

____

Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

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

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
_____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 to 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 to 10?
_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: ______________________________

____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive movement _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: ______________________________

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice
_____Other: ______________________________

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM? ______________________________

How did you hear about us? ______________________________

Doctor Signature: ______________________________

Patient Signature: ______________________________

NAME: **DATE:** / / **Account#:**

SECONDARY COMPLAINT & LOCATION

Location ____________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

___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 to 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 to 10?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ ___Inflexibility ___Stiffness ___Spasms ___Cramps

If the pain radiates or travels, please identify where to: ____________________

QUALITY

How would you best describe the sensation of the pain/symptom:

___ Sharp ___ Stabbing ___ Aching ___ Pins & Needles ___ Pounding ___ Shooting

___ Burning ___ Dull ___ Tingling/Numb ___ Throbbing ___ Crawling ___ Stinging

Over the past weeks/months this complaint is: ___Improving ___Getting worse ___About the same

THIRD COMPLAINT & LOCATION

Location ____________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

___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 to 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 to 10?

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ ___Inflexibility ___Stiffness ___Spasms ___Cramps

If the pain radiates or travels, please identify where to: ____________________

QUALITY

How would you best describe the sensation of the pain/symptom:

___ Sharp ___ Stabbing ___ Aching ___ Pins & Needles ___ Pounding ___ Shooting

___ Burning ___ Dull ___ Tingling/Numb ___ Throbbing ___ Crawling ___ Stinging

Over the past weeks/months this complaint is: ___Improving ___Getting worse ___About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

____

____

2. What do you enjoy doing most in your life?

____

____

NOTES / COMMENTS:

____

____

____

Doctor Signature: ____________________

Patient Signature: ____________________

NAME: DATE: / / Account#:

Please place a checkmark by the condition that applies to you: P = Present • N = Not Present • PP = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Paralysis
			Difficulty of Speech

P = Present • N = Not Present • PP = If it has ever been present in the past • Do the same for your family
Family History Key: F = Father • M = Mother • B = Brother • S = Sister • GF = Grandfather • GM = Grandmother

Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO
Do you think you may be pregnant? _____YES _____NO

FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

- ❏ Allergic / Immunologic
- ❏ Constitutional
- ❏ Endocrine
- ❏ Gastrointestinal
- ❏ Genitourinary
- ❏ Integumentary
- ❏ Neurological
- ❏ Respiratory
- ❏ Cardiovascular
- ❏ Ears / Nose / Mouth
- ❏ Eyes
- ❏ All other system reviews negative
- ❏ Hematological / Lymphatic
- ❏ Musculoskeletal
- ❏ Psychiatric

Notes / Comments: ______________________________

Doctor Signature: ______________________________

Patient Signature: ______________________________

NAME: ______________________ DATE: ___/___/___ Account#: ______________________

PLEASE LIST PAST SURGERIES:

1. ______________________ Year______ 2. ______________________ Year______

3. ______________________ Year______ 4. ______________________ Year______

5. ______________________ Year______ 6. ______________________ Year______

List any other key slips, falls or accidents you've had from childhood to present:		Date	Have you ever taken:	YES	NO	YEAR
1)			Insulin			
2)			Cortisone			
3)			Thyroid Medicine			
4)			Male/Female Hormones			
5)			Blood Pressure			
What medications are you currently taking? (Include Date)			Tranquilizers/Sedatives			
1)	4)		Birth Control			
2)	5)					
3)	6)					
Hospitalizations:						

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: ____ Children's Name(s): ______________________

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately __ REGULARLY

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately __ REGULARLY

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____Yes ____No

Hobbies: ______________________

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: ______________________

Doctor Signature: ______________________

Patient Signature: ______________________