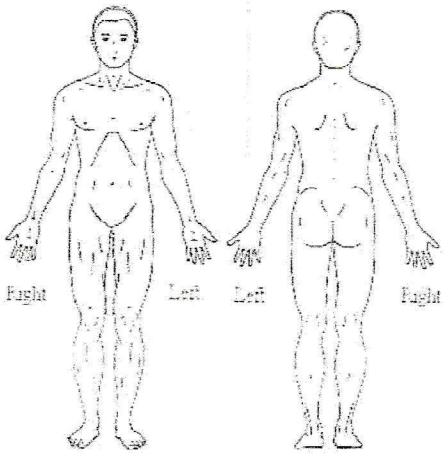
Office of Peter W. McManus, D.C.

CASE HISTORY Email_____

Name _____ Age _____ Date _____
Address _____ City _____ State_____ Zip_____
Phone (Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W
Social Security # _____ Driver's License #_____
Occupation Employer _____ Phone (Work)_____
Insurance Company_____ Phone_____
Insured's Name _____ Insured's Date of Birth _____
Insured's ID. # or S.S. # _____
Spouse's Name _____ Spouse's Occupation _____
Spouse's Employer _____ Spouse's Phone (Work)_____
Spouse's Insurance Co. _____ Phone_____
Spouse's Social Security # _____
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

HEALTH REPORT:

Reason for seeking care: _____
List any other doctors seen for this: _____
List any diagnosis and type of treatment: _____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
List the names of any relatives that have or have had a similar problem: _____
Have you or any relative received chiropractic treatment previously? __ Yes __ No
If yes, explain: _____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____
Are you currently taking medication? __ Yes __ No list medications: _____
_____
Have you taken medication in the past? __ Yes __ No list medications _____
List conditions you are taking medications for: _____
List the approximate dates of any surgery or treated conditions:_____
_____
Family History: Health conditions, age of death and cause of death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____
Do you smoke Y/N ____ •Alcohol Y/N __Daily __Weekly __Social Occasions •Caffeinated drinks per day ____
Do you take Vitamins/Supplements Y/N If yes, type and how often _____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///
Pins, Needles	+ + +
Other _____	^ ^ ^

What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work?_____
Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
_____

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Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient
Signature_____ Date_____

Please feel free to write any further relevant medical history on a separate sheet. If you have any special studies (MRI/X-ray etc) please make plans to bring them to your first visit.
If you would like a report written to your medical primary care physician discussing your condition and treatment plan, please provide the mailing address below. I am happy to do this as I feel it is important that all of your providers are in contact so that we may coordinate care.

_____
_____
_____

Financial Policy
Peter W. McManus, D.C. LLC.
2551 N Clark St. #605, Chicago, IL 60614 & 73 W. Monroe St. #605, Chicago IL 60603

PLEASE READ, FILL OUT COMPLETELY, AND SIGN BELOW.

Thank you for choosing me as your chiropractic physician. I am committed to your treatment being a success. Please understand that paying you bills is part of the covenant between doctor and patient that this allows me to continue to practice and to bring the highest level of service to you and all my patients. The following is a statement of my financial policy and **must be signed and filled out in completely prior to treatment being rendered.** By signing this statement, you are signifying that you understand and agree to the following.

My preferred method of dealing with payment is to keep a credit card on file and to charge whatever fees were accrued during the week at the end of the same week. This saves me from collecting monies during our time in the office together and allows me to focus solely on your clinical needs in the moment.

PAYMENT: Payment options are available. As methods of payment, my office accepts Visa Mastercard and Discover, check or cash. Please ask about a payment plan if you are unable to pay for treatment in full at the time of service or if you anticipate that you will not be able to pay any remainder billing, I am happy to work with you as best as I can. This office and in fact my life's work are about patient care and my main priority is seeing that you get what you need. All special arrangements must be made in advance of treatment. By signing below, you agree that if you default and do not make payments in accordance with the terms in this contract, **you are responsible for all legal and collection costs associated with your bills up to and including legal fees or the costs of hiring a collections service to recover any moneys owing.**

MISSED APPOINTMENTS: Unless a Notice of cancellation of appointment is received 24 hours in advance of the appointment being canceled, I understand that my card on file will be charged a fee of $40.00. Please help me deliver the best services by keeping your appointments. As I schedule on the ½ hour and try very hard to keep on schedule, if you miss an appointment It represents a waste of a half hour of my time that could be spent helping another patient and this missed appointment policy will be enforced 100 percent of the time without exception.

INSURANCE: Insurance companies may cover or reimburse either all, partial amounts or nothing at all relative to care rendered in the office. I am contracted with many insurance companies and am usually considered "in network" or as a "participating provider", however, this may vary with some out of state policies even if I participate with their Illinois affiliate. It is your responsibility to ensure that my services are covered within your policy. I can check this for you but it is ultimately your responsibility and miscommunications do not absolve you from responsibility for payment. I am happy to file insurance claims as a courtesy to you, but this office can not accept responsibility for collecting your insurance claim or negotiating settlement for you on a disputed claim. Your coverage is a contract between you and your insurance company. With your signature below you give me permission to bill your insurance company on your behalf and understand, in plain English, that the financial responsibility is ultimately yours.

I, the undersigned, have read the above contract and understand all financial and legal covenants herein. I understand that, regardless of any insurance coverage, I am legally responsible for any balance due on my account. This includes, but is not limited to, exams, treatments, special studies X-ray studies, MRI etc.) as well as the dispensation of any orthotics or special devices. I authorize my insurance benefits associated with treatment in this office to be paid directly to Peter W. McManus, DC LLC. I further authorize Peter W. McManus, D.C. LLC and my current or future insurer to release any information necessary to process my claims. I understand that the office will assist me in processing claims but it is understood that Dr. McManus is not responsible for delays or lack of cooperation/coordination with your insurance company/managed care organization. In the case of divorced parents of a minor patient, the parent financially responsible for the minor under treatment will be responsible for payment as stipulated in all clauses of this contract. Any unpaid balances outstanding more than 90 days after the date that services are rendered will be charged to the card on file (below).

Credit Card #_ _ _ _-_ _ _ _-_ _ _ _-_ _ _ _ Exp. Date _ _ /_ _ / _ _ _ _
Security Code (3 digit code on back of card) _ _ _ Zip code for card billing address _ _ _ _ _

By my signature I certify that I have read and understand the financial policies of Peter W. McManus, D.C. LLC located in Chicago above and I agree to all terms set forth and further give my permission for all financial actions as set forth above with no termination for said permissions.

Signature Date of Signature Printed Name

Peter W. McManus, D.C.
2551 N Clark St. Suite 605
Chicago, IL 60614

Informed Consent for Diagnosis, Care and Treatment

I _____ consent to and authorize Peter William McManus, D.C. and his employees and agents, to provide such diagnosis, care and treatment considered necessary or advisable by my physician(s). I am aware that the practice of chiropractic medicine is not an exact science and acknowledge that no guarantees have been made to me about the result of my examination or treatment at this facility.

I do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues if indicated. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures. A list of complications from therapy follows:

1. **Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
2. **Dizziness:** Temporary symptoms like dizziness and nausea can occur, but are relatively rare.
3. **Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
4. **Stroke:** There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.
5. **Physical Therapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.
6. **Treatment Results:** I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.
7. **Alternative Treatments Available**: Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
8. **Supplements:** While generally safe, I understand that supplements, vitamins, minerals, shakes or other over-the-counter products carry a risk of side effects particularly when used in conjunction with pharmaceuticals. I have disclosed all known allergies and prescription medications to the doctors at Chicago Institute of Natural Health.
9. **Medications:** Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
10. **Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercise is best indicated after the acute phase as it may aggravate an unstable condition/injury. Movement during the acute phase of an injury may be necessary, but should be under appropriate supervision.
11. **Surgery:** Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
12. **Non-treatment:** I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of patient / Guardian _____ Date

(office use only below)

PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was of legal age, oriented to person, place and time, proficient in the English Language, resolute in denying the use of alcohol and/or recreational drug use.

Peter W. McManus, D.C.

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