



Please complete this form in as much detail as possible. All information is strictly confidential.

Patient Information

Date: _____

Name _____

Address _____

City _____ State _____ Zip _____

At times, our office will need to contact you for schedule changes, missed appointments and billing questions. Please checkmark which phone # you would like to be your primary contact #.

Home Phone _____ Cell Phone _____

Work Phone _____

May we E-mail you about subjects related to our office, i.e. office events/seminars, office closings, changes in scheduling, invoice remittance, etc. YES or NO

Your information will not be shared with any 3rd parties.

E-mail Address _____

SSN _____ Age _____ Date of Birth _____ Sex (M) (F)

Weight _____ Have you lost or gained weight recently? _____

Height _____

Marital Status _____ # of Children _____

Referred by _____

Have you ever had chiropractic care before? _____

If yes, for what problem? _____

Family physician's name _____

Office Phone _____

Employer Information

Occupation _____ Employer _____

Are you currently working? YES or NO

Emergency Contact

Name _____ Relation _____

Home Phone _____ Other Phone _____

Chief Complaint and Present Illness

Major complaints and symptoms — please be as specific as you can.

Is this condition due to an accident? YES or NO Date of Accident _____

Type of Accident: Auto Work Home Other _____

What treatment(s) have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic Services None
Other _____

Do you know what caused your complaint(s)? _____

When did your symptoms begin? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you ever had this condition before or a similar condition? _____

If yes, when? _____

Diagnosis of previous physician _____

Have you had to miss any work? _____ Date you last worked _____

Medical History

Have you been treated for ANY conditions in the last year? YES or NO

If yes, please describe _____

DATE OF LAST: Physical Exam _____

Blood Tests _____

Urinalysis _____ MRI _____ CT Scan _____ X-Ray _____

Ultrasound _____ Chemotherapy/Radiation _____

Other Treatments _____

Have you ever had:	YES or NO and Please describe:	Date(s)
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Sprains/Strains	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Hospitalizations	_____	_____
Auto Accidents	_____	_____

What medications are you taking and for what conditions? Please also list what vitamins, minerals, or herbs you may currently be taking and for what conditions. Include below any allergies you may be aware of.

Medications	Vitamins/Minerals/Herbs	Allergies

Females only:

Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? YES or NO

Family History

Please check and indicate relationship.

___ Diabetes _____	___ High Blood Pressure _____
___ Thyroid Disease/Goiter _____	___ Heart Disease _____
___ Tuberculosis _____	___ Cancer _____
___ Kidney Disease _____	___ Muscle, Bone or Nerve Disease _____
Other _____	

Habits

Please indicate quantity with checkmarks.

	None	Light	Moderate	Heavy
Cigarettes				
Other Tobacco				
Recreational Drugs				
Coffee				
Alcohol				
Tea				
Soda				
Water				
Exercise				

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Elbow/upper arm pain	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder
<input type="radio"/>	<input type="radio"/>	Abnormal Weight gain/loss	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control
<input type="radio"/>	<input type="radio"/>	Allergies Headache	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Low back pain
<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>	Mid back pain
<input type="radio"/>	<input type="radio"/>	Ankle/foot pain	<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Neck pain
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Hand pain	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Shoulder pain
<input type="radio"/>	<input type="radio"/>	Birth Control Pills	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Smoking/tobacco Use
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Hip/upper leg pain	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Systematic Lupus
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Thoracic Outlet Syndrome
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Jaw pain	<input type="radio"/>	<input type="radio"/>	Tumor
<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Joint swelling/stiffness	<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Upper back pain
<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Knee/lower leg pain	<input type="radio"/>	<input type="radio"/>	Wrist pain

General

Do you have any health problems not listed above? If so, please list them. _____

Use this space for any additional information you may wish to discuss. _____

Financial Policy

Co-pays are due at the time of visit. Our office will bill your insurance company. You will be responsible for the balance not covered. We will verify your insurance but unfortunately verification with your insurance company does not guarantee actual payment or verified coverage. **You are responsible to know and understand your own benefits.**

I (signed below) understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself and that all services rendered me are charges 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 have read the above Financial Policy and I understand and agree to it. My signature authorizes Assignment of Benefits with North Michigan Ave. Chiropractic and my insurance carrier. I hereby give authorization to North Michigan Ave. Chiropractic for my evaluation and treatment as deemed clinically necessary.

Signature (Patient or Responsible Party)

Today's Date

Name (Print)

Please rate your pain on the scale below. 0=No Pain and 10=Severe Pain

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

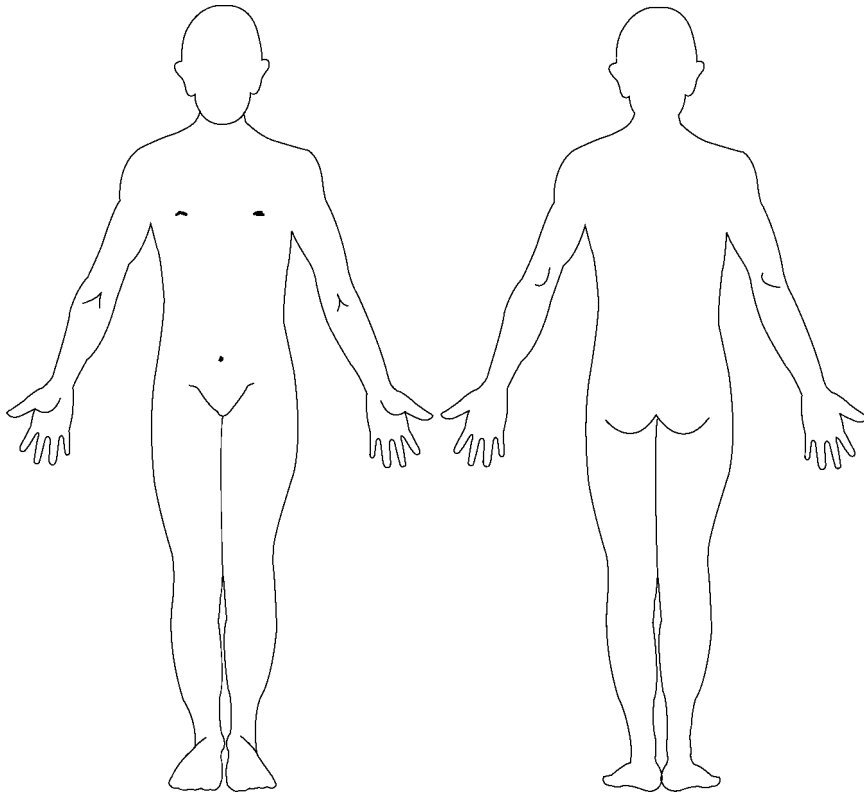
Today's Pain

Pain at its Worst

Typical Pain

Please Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation of symptoms.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching		Stabbing
-----	00000	XXXXX	*****	/////	
-----	00000	XXXXX	*****	/////	
-----	00000	XXXXX	*****	/////	



Visual Analog Scale

The line below represents the intensity of pain. Please mark an "X" at the position on the scale which indicates how much pain you feel at this time.

Name: _____

Date: _____



Your health care provider and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health-related information that may be of interest to you. If this contact is made by telephone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office address. We will not be able to honor your revocation requests if we have already released your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminder, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient's Printed Name

Signature

Date

Personal Representative's Printed Name

Address:
333 N. Michigan Ave.
Suite 1030
Chicago, IL 60601

Personal Representative's Signature

