



Please fill out the following form in as much detail as possible.

Please print.

Patient Information

Date:

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

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

Weight _____ Have you lost or gained weight recently? _____

Married ___ S ___ W ___ D ___ Children _____

Referred by _____

Have you ever had chiropractic care before? _____

If yes, for what problem? _____

Family physician's name _____

Employer Information

Occupation _____

Employer _____

Are you currently working? Yes No

Emergency Contact

Name _____ Relation _____

Home Phone _____ Work Phone _____



Name _____ Date _____

Chief Complaint and Present Illness

Major complaints and symptoms — please be as specific as you can. Ask the doctor or nurse for help if you need assistance in filling out this section. _____

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

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Is this condition due to an accident? Yes No Date of Accident _____

Type of Accident: Auto Work Home Other _____

To whom have you made a report of your accident? Auto Insurance Health Insurance
Employer Work Comp.
Other _____

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

Medications Surgery Physical Therapy Chiropractic Services None
Other _____

Diagnosis of previous physician _____

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

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

If yes, when? _____



Name _____ Date _____

Past Medical History

Give dates if you have had any of the following. (If exact date is unknown, give approximate). Please list the hospital or office these tests were taken, if known.

Physical Exam _____ Blood tests _____
 Urinalysis _____ MRI _____
 CT Scan _____ Ultrasound _____
 Radiation Treatment _____ X-Ray _____
 Other Treatments _____

Injuries / Surgeries:	Description	Date(s)
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other	_____	_____

Medications	Allergies	Vitamins / Supplements

Habits

Please check and indicate quantity.

Cigarettes? _____ Quantity _____ Coffee? _____ Quantity _____
 Alcohol? _____ Quantity _____ Tea? _____ Quantity _____
 Soda? _____ Quantity _____ Water? _____ Quantity _____
 Exercise? _____ Quantity _____



Family History

Please check and indicate relationship.

<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Thyroid Disease/Goiter _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> Muscle, Bone or Nerve Disease _____

<input type="checkbox"/> Other _____	_____
Name _____	Date _____

Female

Date of last menstrual period _____

Do you have reason to believe that you may be pregnant? Yes No

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. _____

I 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.

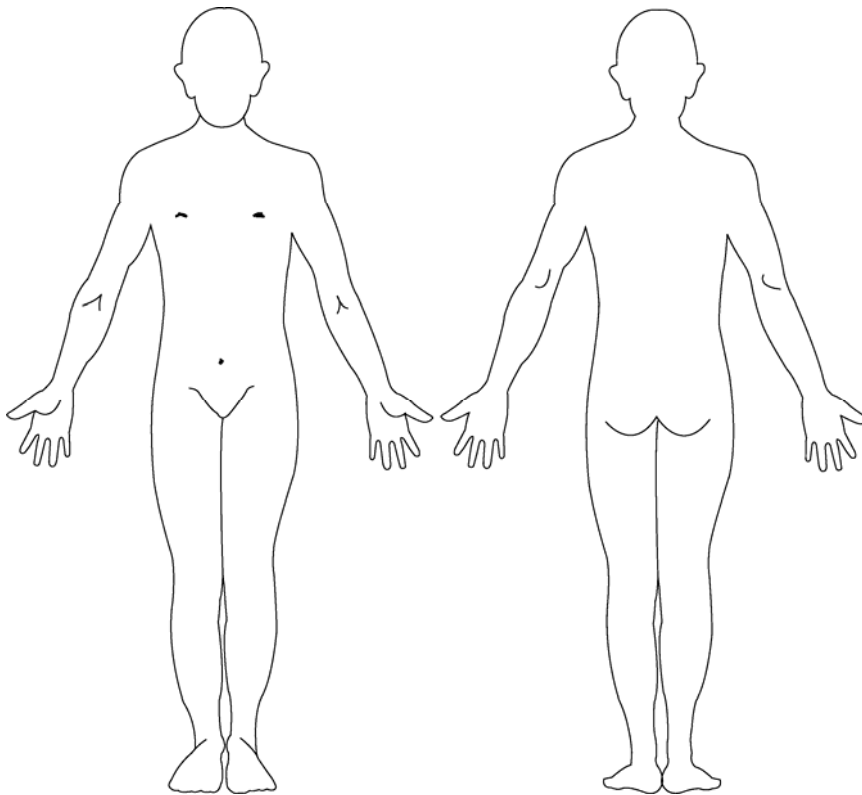
PATIENT SIGNATURE _____ DATE _____

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.
 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

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

Personal Representative's Printed Name

Personal Representative's Signature