New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ○ No ○ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	○ No	○ Yes
Do your symptoms interfere with daily life?	○ No	○ Yes
Does pain wake you up at night?	○ No	○ Yes
Are your symptoms worse during certain times of the day?	○ No	○ Yes
Do changes in weather affect your symptoms?	○ No	○ Yes
Do you wear orthotics?	○ No	○ Yes
Do you take vitamin supplements?	○ No	○ Yes

What activities aggravate your symptoms?

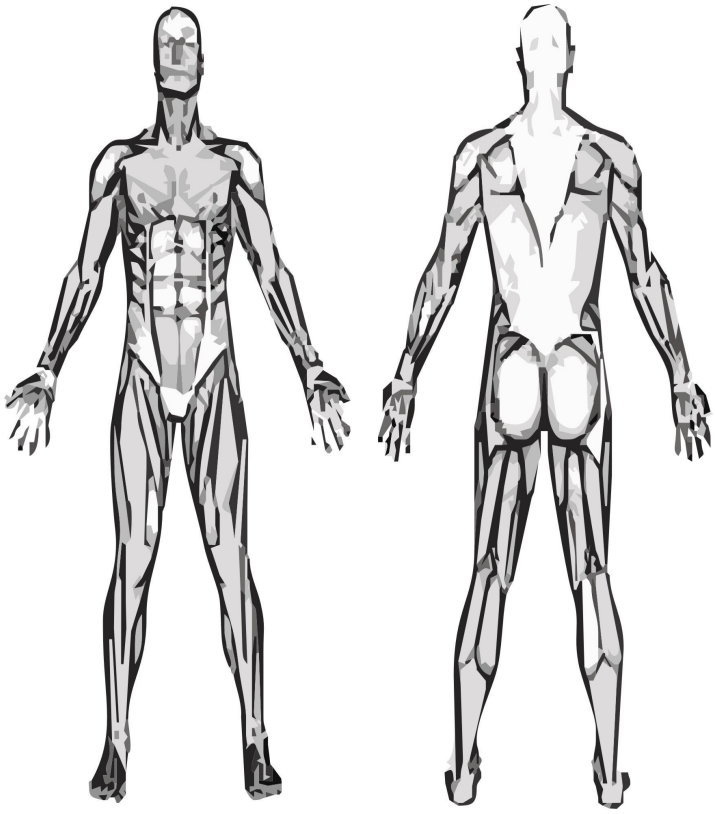
Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

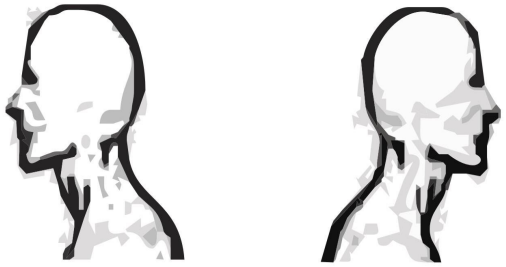
Have you ever suffered from:

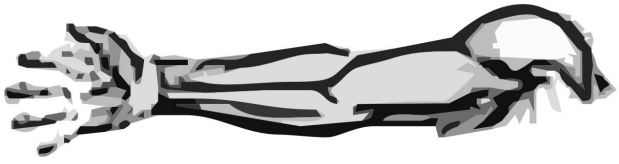
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing







INFORMED CONSENT

The primary treatment used by Chiropractic Physicians is spinal manipulation or adjustments. We will use this procedure in your treatment program, as well as other common secondary treatments such as physiotherapies and modalities.

The Nature of the Chiropractic Manipulation: We will use our hands or a mechanical device to manipulate or loosen and reposition the joint of your body. Often with this procedure, you will hear a "popping" noise, similar to "cracking your knuckles". This is considered normal, and usually gives a pleasant sense of relief.

The Material Risks Inherent in a Chiropractic Manipulation: While serious complications occur only 1-2 times per million adjustments, there is a slight risk, such as fractures, disc injuries, dislocations, sprains, strains, nerve injury, or stroke. Some patients may feel some stiffness or soreness following the first few days of treatment, which is considered normal.

The Probability of Those Risks Occurring: Fractures are rare occurrences, and generally result from some underlying weakness of bone, such as osteoporosis. If you suffer from osteoporosis, we will take special efforts to adjust you carefully. The exact incidence of stroke is uncertain, but is generally believed to occur in less than 1 per 1-3 million treatments. All other complications are generally described as rare.

Ancillary Treatments: In addition to chiropractic adjustments, we intend to use one or more of the following in your treatment protocol.

- **Ice or Hot Packs:** Both may irritate or burn your skin if applied longer than 20-30 minutes without a layer of clothing between your skin and the pack.
- **Electrotherapy:** This modality consists of a mild electrical current, which sends a massage-type action through the muscles and nerves to relax constricted muscles, to block pain impulses, to reduce swelling, and to facilitate healing in muscles and ligaments.
- **Ultrasound:** This modality consists of therapeutic sound wave, which acts as a deep heater for injured tissues. The result is increased circulation to the injured area, which acts to facilitate healing and speed recovery time.
- **Acupuncture:** This is an ancient oriental healing art, which may involve the insertion of fine needles at multiple points in your body. Although slight, some risks include infection, nerve injury, or bleeding. We always use new sterilized acupuncture needles in order to minimize the risks. You may not be a candidate to receive acupuncture treatment if you suffer from hemophilia, bleed easily, or take medication such as blood thinners, anticoagulants, or corticosteroids. Please inform your doctor if any of these risk factors apply to you.
- **Cold or Low Level Laser:** It has been design to mimic solar radiation, producing collagen and vitamin D, and increasing epithelial cell activity, serotonin levels and capillary blood vessel formation at the treatment site. The laser we use is safe, because it is non-thermal and non-invasive. It is an FDA-approved Class II device.
- **Muscle Release Techniques:** These techniques are used to break up adhesions between muscle fibers in tight muscles. This release allows the muscle to return to its proper length, and decrease tightness. Bruising muscle aches and soreness often occur over the next few days following treatment, which is considered normal as it is part.

The Risk & Dangers of Remaining untreated allows the formation of adhesions and reduces joint motion, which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read the above explanation of the Chiropractic care and related treatments I may receive. I have discussed with he doctor and/or staff and have my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment, and have myself decided that it is in my best interest to undergo the health plan recommended. Having been informed of the nature and risks of Chiropractic care, I hereby give my consent to be treated.

_____
Printed Name

_____ _____
Signature Date

Chicago Spine and Joint Care

Office Financial Policy

You are considered a cash patient until you bring in your completed insurance forms, and we verify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.
If your carrier has not paid a claim within sixty (60) days submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card on file to collect full payment.

Cancellation Policy

At Chicago Spine and Joint Care, we understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty dollar ($20) fee; this will not be converted by your insurance company.

We are unable to hold any appointment without a major credit card on file:

Credit Card # _____ Exp. Date _____

Security Code _____ Billing Zip code _____

By signing below, I _____ acknowledge that I have read, fully understand, and will comply the above stated policies.

Signature _____ Date _____