Center For Wellness Chiropractic Care

700 N. Lake St., Suite 102 Mundelein, IL 60060

Date:

Last Name: _____ First Name: _____

Preferred To Be Called: _____ D.O.B.: _____ SS#_____

Email: _____ Phone Number: _____

Address: _____

Employer: _____ Occupation: _____

How did you hear about us? _____

Have You Been Treated by A Chiropractor In The Past? Yes No (circle one)

Tobacco Use:
Alcohol Use:
Work Activities (desk work, labor, etc):
Activity Level: None Light Moderate Vigorous
Hospitalizations (date/reason):
Prior Surgeries (date/location):
Prior Accidents / Injuries (date/injury):
Ongoing Illness, Pains:
Current Medications:
Family History:
Hobbies, Activities, Sports:
Previous Physical, X-rays, Imaging (date/findings):
Dietary Habits, Water Intake:
Nutritional Supplements (vitamins, protein, supplements):
Additional Notes for the Doctor:

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Please check the box next to each condition you have experienced or are experiencing.

GENERAL

- ☐ Lethargy / Weakness
- ☐ Recurring fever
- ☐ Recent weight loss or gain
- ☐ Dizziness
- ☐ Fever
- ☐ Chills
- ☐ Others:

CARDIOVASCULAR

- ☐ Chest pain or tightness
- ☐ Heart attack
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Swelling of feet or hands
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Heart murmur
- ☐ Blood clots
- ☐ Pacemaker
- ☐ Mitral valve prolapse
- ☐ Congenital heart defects
- ☐ Rheumatic fever
- ☐ Leg pain upon walking
- ☐ Varicose veins
- ☐ Dizziness
- ☐ Excessive bruising
- ☐ Coronary artery disease
- ☐ Others:

ALLERGIES

- ☐ Seasonal
- ☐ Medication
- ☐ Food
- ☐ Others:

EENT

- ☐ Headaches or migraines
- ☐ Eye or vision problems
- ☐ Eyeglasses or contact lenses
- ☐ Nose bleeds
- ☐ Eye surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Nose congestion / sinus trouble
- ☐ Ear or hearing problems
- ☐ Dental problems
- ☐ Gum problems
- ☐ TMJ problems
- ☐ Postnasal drip
- Others:

RESPIRATORY

- ☐ Persistent cough
- ☐ Spitting up blood
- ☐ Asthma or wheezing
- ☐ Shortness of breath
- ☐ Exercise intolerance
- ☐ Sleep apnea
- ☐ Emphysema
- ☐ Snoring issues
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Breathing
- ☐ Hay fever
- ☐ Others:

SKIN / HAIR

- ☐ Skin trouble or rashes
- ☐ Flushing
- ☐ Excessive acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Skin pigmentation issues
- ☐ Change in hair or nails
- ☐ Blood in stool
- ☐ Easy bruising
- ☐ Gum bleeding
- ☐ Others:

GASTROINTESTINAL

- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Stomach ulcer
- ☐ Bloating/Cramping
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Difficulty swallowing
- ☐ Jaundice
- ☐ Liver disease
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Change in bowel habits
- ☐ Black or bloody stool
- ☐ Colon cancer or colon polyps
- ☐ Food sensitivities
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Gastric reflux
- ☐ Colitis
- ☐ Others:

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NEUROLOGICAL

- [ ] Frequent headaches
- [ ] Migraines
- [ ] Dizziness
- [ ] Fainting
- [ ] Memory loss
- [ ] Poor balance
- [ ] Numbness or tingling
- [ ] Pins and needles
- [ ] Epilepsy or seizures
- [ ] Stroke
- [ ] Tremors
- [ ] Head injury
- [ ] Anxiety and/or panic
- [ ] Depression
- [ ] Sleeping issues
- [ ] Weak muscles
- [ ] Loss of smell or taste
- [ ] Temporary loss of vision
- [ ] Difficulty concentrating
- [ ] Others:

URINARY

- [ ] Painful or frequent urination
- [ ] Incontinence
- [ ] Hesitancy
- [ ] Urgency
- [ ] Blood in urine
- [ ] Kidney stones
- [ ] Urinary infections
- [ ] Genital / bladder / urinary complaints
- [ ] Others:

MUSCULOSKELETAL

- [ ] Arthritis
- [ ] Joint pain or swelling
- [ ] Neck pain
- [ ] Back pain
- [ ] Trauma
- [ ] Osteoporosis
- [ ] Scoliosis
- [ ] Cramping
- [ ] Fractures
- [ ] Implants, plates, pins or screws
- [ ] Hip disorders
- [ ] Knee injuries
- [ ] Foot / ankle pain
- [ ] Shoulder problems
- [ ] Elbow / wrist pain
- [ ] Poor posture
- [ ] Gout
- [ ] Others:

PSYCHIATRIC

- [ ] Alzheimer's Disease
- [ ] Insomnia
- [ ] Difficulty concentrating
- [ ] Memory loss/confusion
- [ ] Depression
- [ ] Anxiety
- [ ] Agitation/Irritability
- [ ] Suicidal thoughts
- [ ] Chemical dependency
- [ ] Others:

BLOOD / LYMPH

- [ ] Anemia
- [ ] Bleeding
- [ ] Bruising
- [ ] Blood clots
- [ ] Past transfusions
- [ ] Leukemia
- [ ] Lymphoma
- [ ] HIV/AIDS
- [ ] Sickle cell
- [ ] Others:

ENDOCRINE

- [ ] Diabetes
- [ ] Thyroid problems
- [ ] Sweating
- [ ] Heat intolerant
- [ ] Cold intolerant
- [ ] Weight loss
- [ ] Weight gain
- [ ] Frequent urination
- [ ] Excessive thirst
- [ ] Change in appetite
- [ ] Hair changes
- [ ] Hyperthyroidism
- [ ] Hormonal / glandular concerns
- [ ] Hyperparathyroidism
- [ ] Testosterone deficiency
- [ ] Cushing's syndrome
- [ ] Steroid treatments
- [ ] Others:

ANY ADDITIONAL COMPLAINTS YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT?

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Primary Complaint:

Additional Complaints:

DATE OF INJURY / SYMPTOM ONSET:

TREATMENT RECEIVED : MEDICATION – SURGERY – CHIROPRACTIC – PHYSICAL THERAP Y – OTHER – NONE

HOW DID YOUR INJURIES HAPPEN:

SYMPTOMS EXPERIENCED: CONSTANTLY - FREQUENTLY - OCCASIONALLY - INTERMITTENTLY

SYMPTOMS INTEREFERE WITH: WORK – SLEEP – DAILY ROUTINE – RECREATION

ACTIVITIES PAINFUL TO PERFORM:

WHAT WORSENS YOUR SYMPTOMS:

WHAT IMPROVES YOUR SYMPTOMS / PROVIDES RELIEF:

ARE YOUR SYMPTOMS GETTING WORSE: YES NO HOW? :

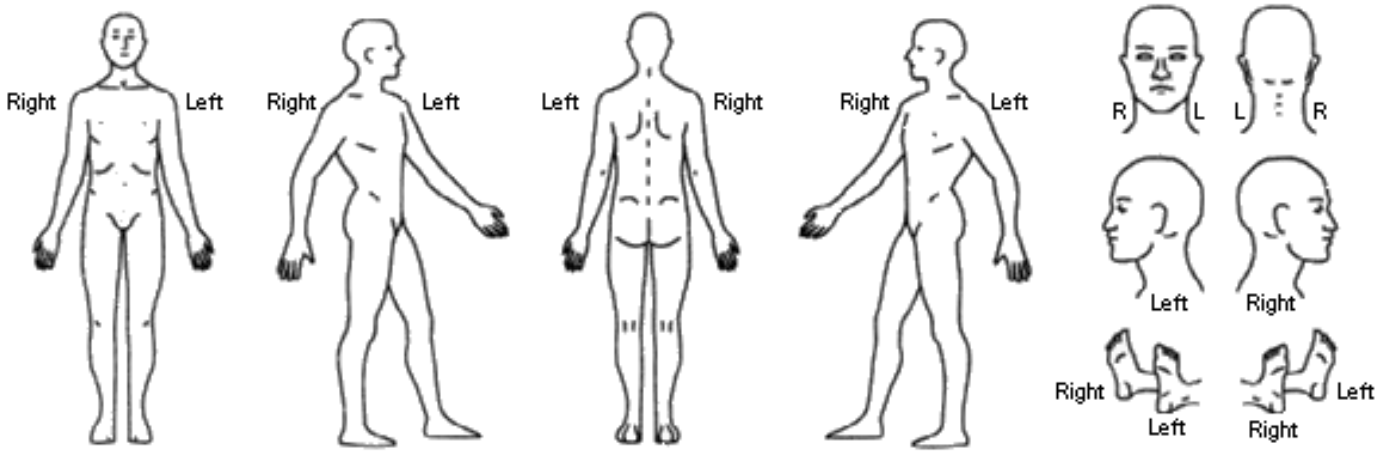
OVERALL HEALTH: (CIRCLE BEST ANSWER): EXCELLENT - VERY GOOD - GOOD - FAIR - POOR

CIRCLE YOUR AVERAGE PAIN INTENSITY

- **CURRENT PAIN LVL:** **1 2 3 4 5 6 7 8 9 10**
- **AVERAGE PAIN LVL:** **1 2 3 4 5 6 7 8 9 10**

TYPES OF PAIN: Mark all that apply

☐ ACHING ☐ DULL ☐ STABBING ☐ NUMBNESS ☐ TINGLING
☐ BURNING ☐ SHARP ☐ THROBBING ☐ STIFFNESS ☐ OTHER



MARK THE PAINFUL REGIONS ON THE DIAGRAMS ABOVE WITH (X).

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Dr. Jonathan Engstrom DC, CCSP, CKTP

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, massage therapy to myself (or on the patient named below, for whom I am legally responsible) by the chiropractic physician and/or any employee at Center For Wellness authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic Medicine ___Dr. Jonathan Engstrom___ and/or other employees who may treat me now or in the future at Center For Wellness. I understand the nature and purpose of chiropractic adjustments and other procedures, and that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic care carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of treatment which the physician feels is in my best interest at the time based upon the objective information present.

I have read, or have been read to, the above consent. I have also had an opportunity to ask questions about the contents of the consent form, and by signing below, I agree to the treatment recommended by my physician. I acknowledge that the Notice of Privacy Practices for Center For Wellness has been made available to me at the time of my signing this consent form. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at Center For Wellness.

Furthermore, by signing below I acknowledge that I will be subject to a charge of **$50.00** if I fail to cancel or reschedule an appointment within 24 hours of my scheduled appointment with Center For Wellness. By signing I authorize CFWCC to communicate via text message applications.

_____ Print Patient Name (Adult)

_____ Patient Signature

_____ Print Patient Name (Minor)

_____ Print Representative / Guardian Name

_____ Representative / Guardian Signature