



APPLICATION FOR CARE AT WHEATON FAMILY CHIROPRACTIC

2150 Manchester Rd. Suite 100 | Wheaton, IL | 60187 | 630-868-8480



Today's Date: _____

VRC#: _____

Who referred you to our Clinic? _____

PATIENT DEMOGRAPHICS

Full Name: _____ Birth Date: ____ - ____ - ____ Age: _____

Male Female Marital Status: S M D W O Do you have Insurance: No Yes _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Mobile Phone: _____ Home Phone: _____

I authorize my email and phone to be added to Wheaton Family Chiropractic database for email, text alerts, & product promotion.

Driver's License #: _____ Occupation: _____

Employer: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of Children & Ages: _____

Emergency Contact (Name & Number): _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Second: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number**:

Primary chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM Mid-Day

How long does it last? Constant On and off during the day It comes and goes throughout the week

How did the injury happen? _____

Is your problem the result of ANY type of accident? Yes No

If **Yes**, identify type: Auto Work Home Other (please explain): _____

Date of Accident: ____ / ____ / ____ Approximately what time of day? _____ AM PM

Have you reported this accident to anyone? No Yes If yes, to whom: _____

Condition(s) ever been treated by anyone in the past? No Yes

If **Yes**, when: _____ by whom? _____ How long were you under care? _____

What were the results? _____

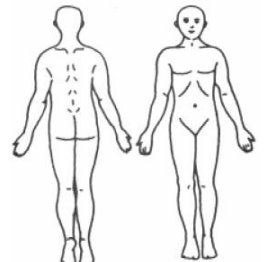
Name of Previous Chiropractor's Name? _____ N/A

Clinic Name & Contact Info? _____
(If applicable)

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms: →
R=Radiating, **B**=Burning, **D**=Dull, **A**=Aching, **N**=Numbness, **S**=Sharp/Stabbing, **T**=Tingling

What relieves your symptoms? _____

What makes them feel worse? _____



Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

ACTIVITIES OF DAILY LIVING

Identify how your current condition is affecting your ability to carry out daily activities that are routinely part of your life:

Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading / Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Washing/ Bathing/ Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sweeping / Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Taking out Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Other:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Other:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

Please give us more information regarding your most restricted activity due to your condition and your usual ability before you suffered your condition.

LIST RESTRICTED ACTIVITY LEVEL:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

Example: Walking without Pain

¼ mile

2 miles

Example: Sitting without Pain

15 minutes

4 hours

_____ :

_____ :

_____ :

_____ :

LIST PRESCRIPTION & NON-PRESCRIPTION DRUGS YOU TAKE:

PAST HISTORY

Have you suffered with your current complaint, or a similar problem in the past? No Yes If yes, how many times: _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: No Yes If yes, please state what type of treatment: _____,

Who provided it? _____ How long ago? _____ What were the results? Favorable Unfavorable→

Please explain. _____

Identify any and all **types of jobs** you have had in the past that have imposed any physical stress on your body:

When was your most recent **auto accident**? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

How many total auto accidents in your life? _____

When was your most recent **strain/ stress at work**? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures? _____
(i.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past: _____

(i.e. Contact/ quick burst/ repetitive motion sports? football, wrestling, basketball, baseball, soccer, tennis, golf, track & field)

Traumas as a child? _____

(i.e. fall on your head, impact to your head, concussion, fall onto back or tailbone, biking accident)

Work around the house? _____

(i.e. lifting, bending, woke up with a stiff neck, "back went out")

PLEASE MARK "P" FOR PAST , "C" FOR CURRENT , "N" FOR NEVER:

- | | | | | |
|--|----------------------------|---------------------|----------------------------|--------------------------|
| ___ Headache | ___ Pregnant | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/SexualDysfn. | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Convulsions/Epilepsy | ___ Fainting | ___ Digestive Problems | ___ Heart Problem |
| ___ Shoulder Pain | ___ Tremors | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Chest Pain | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Pain w/Cough/Sneeze | ___ Ringing in Ears | ___ Menstrual Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot or Knee Problems | ___ Hearing Loss | ___ Menopausal Problems | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disability | ___ Gall Bladder |
| ___ Broken Bone | ___ Dislocation | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble |
| ___ Disability | ___ Cancer | ___ Allergies | ___ Trouble Sleeping | ___ Hepatitis (A, B, C) |
| ___ Numb/Tingling arms, hands, fingers | | ___ Tumors | ___ Fracture | ___ Rheumatoid Arthritis |
| ___ Numb/Tingling legs, feet, toes | | ___ Heart Attack | ___ Osteo Arthritis | ___ Diabetes 1 or 2 |
| ___ Other: _____ | | | ___ Other: _____ | |
| ___ Other: _____ | | | ___ Other: _____ | |

PAST HISTORY RELATED TO CURRENT CONDITION:

Identify ALL PAST and any CURRENT conditions you feel may be contributing your present problem:

WHAT	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
Injuries:			
Surgeries:			
Childhood Diseases:			
Adult Diseases:			

SOCIAL HISTORY:

- 1. Smoking: cigars pipe cigarettes How often? Daily Weekends Occasionally Never
- 2. Alcoholic Beverage: consumption occurs Daily Weekends Occasionally Never
- 3. Recreational Drug use: occurs Daily Weekends Occasionally Never
- 4. Hobbies-Recreational Activities-Exercise: Daily Weekends Occasionally Never

FAMILY HISTORY:

- 1. Does anyone in your family suffer with the same condition(s)? No Yes
 If yes what? _____
 And, whom? Mother Father Grandmother Grandfather Sisters Brothers
 Son(s) Daughter(s) Other: _____
 Have they ever been treated for their condition? No Yes I don't know
- 2. Any other hereditary conditions the doctor should be aware of? No Yes: _____
- 3. Height of patient's Mother: _____ Father: _____

Any additional comments: _____

I hereby authorize payment to be made directly to Wheaton Family Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Wheaton Family Chiropractic for any and all services I receive at this office.

Patient's Signature

Date Completed

Doctor's Signature

Date Form Reviewed

QUADRUPLE VISUAL ANALOGUE SCALE

Patient's Name: _____

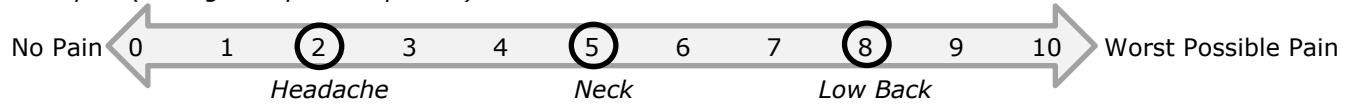
Date: ____/____/____

INTENSITY RATING

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

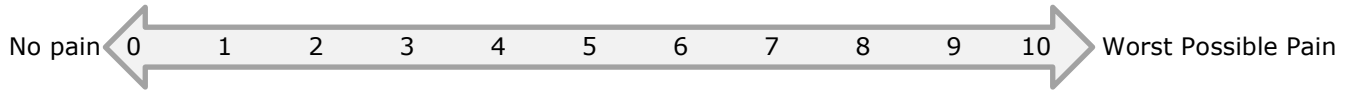
Example: (Listing Multiple Complaints)



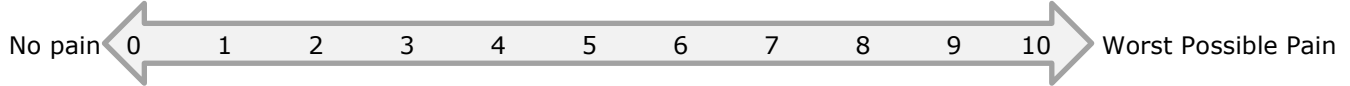
1. What is your pain **RIGHT NOW**?



2. What is your **TYPICAL or AVERAGE** pain?



3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

Neck: Mid Back: Low Back: Headache:	Goal:
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Examiner: _____

Date: ____/____/____

WHEATON FAMILY CHIROPRACTIC INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Wheaton Family Chiropractic have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ / _____ / _____ *Witness Initials*
Patient or Authorized Person's Signature _____ *Date*

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully, and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on _____ / _____ / _____ Date

I have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MALES/ FEMALES → By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

_____ / _____ / _____ *Witness Initials*
Patient or Authorized Person's Signature _____ *Date*

WHEATON FAMILY CHIROPRACTIC NOTICE OF PRIVACY POLICY

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. Below is a brief summary of these circumstances. Once you have read this notice, please sign.

PERMITTED DISCLOSURES:

1. Treatment purposes – discussion with other health care providers involved in your care
2. Inadvertent disclosures – open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency – in the event of a medical emergency we may notify a family member
6. For Public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or the general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please the office at 630-868-8480. If we are unavailable, you may make an appointment with our receptionist to see her / him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 2020

I have read and understand Wheaton Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at any time in the future and will make the new provisions effective for all information that it maintains past and present.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Printed Name

DOB

Patient signature

Date

Witness

Date

WHEATON FAMILY CHIROPRACTIC OFFICE POLICIES

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

YOUR CARE – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Wheaton Family Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to the latest techniques for spinal correction. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

FIRST THINGS FIRST – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge that I have read and understood the practices 'Office Policies.' This signature page will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient's Printed Name

DOB

Patient signature

Date

Witness

Date