Dr. Robert Wright, DC, CBCN

Welcome to Chiro-Med Health & Wellness Centers

Patient Information

Thank you for choosing Chiro-Med for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Name: _____ SS/HIC/Patient ID #: _____
First Middle Initial Last

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

Sex: ❑ Female ❑ Male Birthdate: _____ E-mail: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for ____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (_____)_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (_____)_____

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

Name of employer: _____ Work Phone: (_____)_____

Insurance Information

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#: _____ Date employed: _____

Name of employer: _____ Work Phone: (_____)_____

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

Insurance Co.: _____ Phone: (_____)_____ Group #: _____ Employer #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip Code: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have additional insurance? ❑ Yes ❑ No **If Yes, please complete the following:**

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#:: _____ Date employed: _____

Name of employer: _____ Work Phone: (_____)_____

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

Insurance Co.: _____ Phone: (_____)_____ Group #: _____ Employer #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip Code: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

CONFIDENTIAL

NAME: DATE: / / Account#:

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

TIMING & DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent ____Occasional

What caused the onset? _____

_____

Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: _____

_____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive movement _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice
_____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM? _____

How did you hear about us? _____

Doctor Signature: _____

Patient Signature: _____

NAME: DATE: / / Account#:

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting

_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting

_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

_____

_____

2. What do you enjoy doing most in your life?

_____

_____

NOTES / COMMENTS:

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: DATE: / / Account#:

Please place a checkmark by the condition that applies to you: P = Present • N = Not Present • PP = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Paralysis
			Difficulty of Speech

P = Present • N = Not Present • PP = If it has ever been present in the past • Do the same for your family
Family History Key: F = Father • M = Mother • B = Brother • S = Sister • GF = Grandfather • GM = Grandmother

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	Family History					
					F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO
Do you think you may be pregnant? _____YES _____NO

FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

- ❑ Allergic / Immunologic
- ❑ Constitutional
- ❑ Endocrine
- ❑ Gastrointestinal
- ❑ Genitourinary
- ❑ Integumentary
- ❑ Neurological
- ❑ Respiratory
- ❑ Cardiovascular
- ❑ Ears / Nose / Mouth
- ❑ Eyes
- ❑ All other system reviews negative
- ❑ Hematological / Lymphatic
- ❑ Musculoskeletal
- ❑ Psychiatric

Notes / Comments: _____

Doctor Signature: _____

Patient Signature: _____

NAME: _____ DATE: ____/____/____ Account#: _____

PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year_____
3. _____ Year_____ 4. _____ Year_____
5. _____ Year_____ 6. _____ Year_____

List any other key slips, falls or accidents you've had from childhood to present:	Date
1)	
2)	
3)	
4)	
5)	

What medications are you currently taking? (Include Date)	
1)	4)
2)	5)
3)	6)

Have you ever taken:	YES	NO	YEAR
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

Hospitalizations:

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: ____ Children's Name(s): _____

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately ___ REGULARLY

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately ___ REGULARLY

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____Yes ____No

Hobbies: _____

Patient history was obtained from: ____Patient ____Father ____Mother ____Son ____Daughter

Notes / Comments: _____

Doctor Signature: _____

Patient Signature: _____

Chiro Med
Health & Wellness Centers

- Board Certified Chiropractic Physicians and Medical Doctors on Staff
- Members; American Chiropractic Association
- Advanced training in treatment of Soft Tissue Injuries, Whiplash and Spinal Trauma
- Post-Graduate Training in BioPhysics and the treatment of Sports related injuries
- Certified Injury Prevention and Ergonomic Evaluation Consultants
- Consultants and Lecturers Back injury prevention Optional Health & Stress Relief
- Nutritional Counseling, Dietary Supplementation and Natural Medicine
- Certified to Evaluate Functional Capacity and Impairment/Disability Ratings

Notice of Privacy Practice

You may inspect and receive copies of your medical records. Records will be provided within 30 days of a written request to do so. There may be a reasonable fee for photocopying, postage and preparation of the requested records; you are responsible for this fee. Any information we collect about you will be kept confidential in our office. If a claim is submitted to an insurance company, your health information may be shared for payment purposes.

You may file a complaint regarding the privacy practices of our office by calling us at (708) 403 2727. Also, you can complain directly to the Department of Health and Human Services Office for Civil Rights (OCR), which is charged with investigation complaints and enforcing the privacy regulations. You can find more information about filing a complaint by calling (866) 627-7748.

The following practices are utilized in our office: sign-in-sheets, open treatment areas and direct mail. Our office can accommodate a patient's need for further privacy when necessary; please let us know!

Policies and Procedures

Cancellations

You will be charged $25 for no-shows and for cancellations made less than 24 hours prior to a scheduled treatment. Please note that frequent cancellations, with or without 24-hour notice, may result in the loss of your time slot and your release from care at the doctor's discretion.

Payments

Payment for services will be collected prior to services rendered. For example, a co-pay will be collected prior to treatment. If our office is unable to verify insurance coverage prior to providing services you will be responsible for all charges until verification can be made. Available payment methods are cash, check, and credit cards. Any fees related to a check returned for insufficient funds will be paid by you immediately. In cases where payment is not made prior to treatment and you fail to respond to our billing attempts, your account will be sent to a professional collections agency and you will be responsible for fees associated with collection activities; a 30% surcharge will be added to what you owe. For example, if you fail to pay $100 bill, our collection agency will be informed that you owe $130.

We have the right to change this notice in the future.

Thank You.

My signature acknowledges that I have been given an opportunity to review and have received a copy of these Notice of Privacy Practices & Policies and Procedures.

Sign: _____ Date: _____

9441 W. 144th Place
Orland Park, IL 60462
(708) 403-2727
(708) 403-2770 fax

"The Experts At Improving Your Health, Naturally."

Orland Park Integrative Health

9441 W. 144th Place, Orland Park Il 60462

CONSENT TO CARE

A patient coming to the doctor gives their permission and authority to care for them in accordance with appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare, if they are aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defect\s, illnesses or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities whether related to the prescribed care or ortherwise, will be resolved by binding arbitration under the current malpractice terms, which can be obtained by written request.

I have read and understand the foregoing:

Signature: _____ Date: _____

BELOW FOR WOMEN ONLY: X-RAY QUESTIONNAIRE

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you ARE NOT pregnant at this time.

NAME: _____

- O There is a possibility that I may be pregnant at this time
- O Yes, I am definitely pregnant
- O No, I am definitely not pregnant at this time
- O I request that x-ray films not be taken because _____

Date of last menstrual period: _____

Signature: _____ Date: _____