palos chiropractic and holistic health

Patient History

TODAY'S DATE: _____ E - Mail: _____

NAME: _____ HOW WOULD YOU LIKE TO BE ADDRESSED? _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

YOUR ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ SS #: _____ HOME #: _____

YOUR OCCUPATION: _____ WK #: _____

EMERGENCY CONTACT _____ PH #: _____ CELL #: _____

MARITIAL STATUS **S M W D** How Were You Referred To Our Office?: _____

HOW MANY CHILDREN DO YOU HAVE? _____ WHAT ARE THEIR AGES? _____

HAVE THEY OR ANY OTHER MEMBERS OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? ❑ Yes ❑ No

HAVE YOU EVER HAD CHIROPRACTIC CARE? ❑ Yes ❑ No HOW LONG HAS IT BEEN? _____

THE PURPOSE OR REASON FOR THIS APPOINTMENT? _____

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES? _____

DO YOU SMOKE? ❑ Yes ❑ No HOW MUCH? _____

DO YOU EXERCISE ❑ Yes ❑ No HOW OFTEN? _____ TYPE? _____

DO YOU HAVE ANY ALLERGIES? (SPECIFY): _____

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

Y N *Broken or Fractured Bones	Y N *Osteoarthritis	Y N Eating Disorder
Y N Circulatory Problems	Y N Epilepsy	Y N Alcoholism
Y N *Rheumatoid Arthritis	Y N Pacemaker	Y N Drug Addiction
Y N Seizures/Convulsions	Y N Strokes	Y N HIV Positive
Y N A Congenital Disease	Y N *Cancer	Y N Gall Bladder
Y N Excessive Bleeding	Y N Ulcers	Y N *Head Problems
Y N High/Low Blood Pressure	Y N Ruptures	Y N Depression
Y N *Diabetes	Y N Coughing Blood	Y N Tumors

* Explanation: _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

FOR DOCTOR'S USE ONLY

❑ GENERAL

INJURY TYPE:

❑ NDRA

DRUG ALLERGIES:

❑ SEE MEDS ADDENDUM

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED DR. / SELF	
						D	S
						D	S
						D	S
						D	S
						D	S

Patient History - Chief Complaint

Dr. Robert Wright, DC, CBCN
Chiropractic Physician
Clinical Nutritionist

Patient Name: _____ **Date:** _____

Current E-Mail Address: _____

1. What is your **main complaint?** _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At its worst)

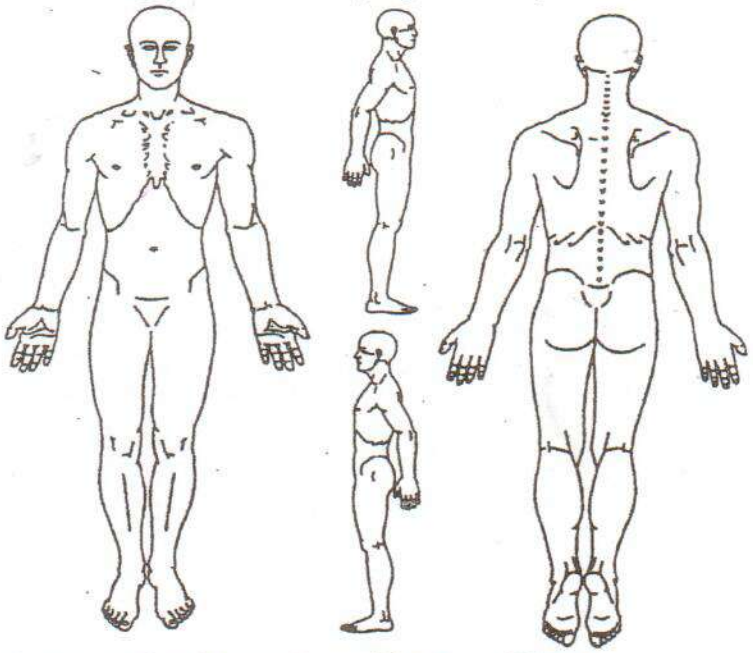
None		Slight		Mild		Moderate			Severe
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

	Occasional		Intermittent			Frequent			Constant	
0	10	20	30	40	50	60	70	80	90	100 %

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? Yes No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates?_____ to _____
12. Are you Pregnant? ❑ Yes ❑ No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

Signature:_____

Date: ____/____/____

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Insurance Information

Dr. Robert Wright, DC, CBCN
Chiropractic Physician
Clinical Nutritionist

(708) 671-1400 www.PalosChiro.com
12770 S. Harlem Ave. Palos Heights IL 60452

Patient Name: _____ Today's Date: _____

Insured's Information:

Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone (home): _____ E-Mail: _____

Date of Birth: _____

Occupation: _____ Employer _____

Phone (work): _____ Insured's Soc. Sec. # _____

Insured's relationship to patient: _____

Insurance Company: _____ Phone: _____

GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I certify that the above information has been accurately answered.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payors and / or health practioners.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. I understand that in some cases these procedures will be carried out by staff other than the physician, but that they will be under the supervision of the physician in this facility.

I understand all original x-rays remain on file in the clinic. If they need to be used for an outside consultation, a digitial copy of the images will be produced and copied onto a CD that I can take to my outside doctor for review. The fee for an imaging CD is $5.00 and must be paid in advance. 72 hours notice is required for imaging duplication.

By signing below, I authorize the **Dr. Robert Wright, DC, CBCN** to carry out all verbally authorized care.

Signature: _____ **Date:** _____

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Dr. Robert Wright, DC, DCBCN
Chiropractic Physician / Clinical Nutritionist

FINANCIAL AGREEMENT 12122017

- INSURANCE PATIENTS: I understand I am responsible for all co-payments, deductibles, and co-insurance as per the terms of my contract with my insurance carrier.
- I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore, there is no guarantee of payment by my insurance carrier.
- I am responsible for updating my health insurance information with the office any time the information changes, terminates, or new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
- Authorization to Release Information: I hereby authorize the Provider to release any information required to process my claim(s.)

- SELF-PAY PATIENTS: All self-pay patients are required to pay at the end of each visit. No balances past 90 days will remain in the office and will be moved to an outside vendor for collection.

Patient Signature/Date: _____ _____

Insured Signature/Date: _____ _____

Signatue of Guardian / Date: _____ _____

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HIPPA PATIENT CONSENT FORM 092418

We are required by the Health Insurance Portability & Accountability Act of 1996 (HIPPA) to maintain the privacy of your protected health information (PHI).

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment and health care operations.

The patient may revoke this Consent in writing at any time and all future disclosure that require the patient's prior written consent will then cease.

_____

Printed Name or Patient or Representative

_____

Signature / Date

Relationship to Patient (if other than patient): _____

( ) Patient Refused to Sign

( ) Patient unable to sign for the following reason: _____

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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: _____

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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: _____