Dr. Robert Wright, DC, CBCN
Doctor of Chiropractic
Clinical Nutritionist
Applied Kinesiologist

palos chiropractic & holistic health

NEW LOCATION IN ORLAND PARK
In Chiro-Med Health Center
9144 W. 144th Place, Orland Park

WELCOME !

You have made a wise health choice in choosing our holistic and natural healthcare office. This is the office where people gain control of their health. Here, they will heal, strengthen, and then learn how to keep control of their health through manageable steps, and learning.

2020 NUTRITIONAL PROGRAMS' FEE SCHEDULE071720

Pre-Visit Phone Consultation	No Charge
Initial Visit - NEW PATIENT - Thorough Examination - 45 minutes	$150
Initial Visit - CROSSOVER PATIENT (crossover from Chiropractic) - Thorough Examination - 45 Minutes	$125
Follow-Up Visit – In Office - 20 minutes	$65
Follow-Up Visit – via Phone Consult - 10 minutes	$40

PATIENT: PLEASE RETAIN PAGES 1 & 2 FOR YOUR RECORDS

Page 2
PCHH Nutritional Fees & Policies

Financial:

- Payment is due at each visit
- Methods of payment are: Cash, Personal Check, Credit Card or *CareCredit
  * CareCredit: A revolving open line of credit for health/dental/vision/veterinary care (Inquire at Front Desk on 3, 6& 9 month programs @ 0%)
- This facility applies a $35.00 fee to any checks returned as NSF (Non-Sufficient Funds.)
- This facility allows a maximum family balance of $125.00. Should a personal balance meet or exceed this maximum allowed, it is required that payment arrangements be discussed with the Office Financial Department.
- Patient/Guardian understands that once a financial agreement has been put into place on his/her behalf, missed payments or failure to comply with this said agreement, patient/guardian will immediately be considered in breach of this agreement and the said account is subject to alternative collection efforts

Appointments

- Keeping your scheduled appointments are extremely important to the success of your care.
- Each visit builds upon the prior one.
- Dr. Wright's treatment recommendations are based on success with previous patients who have experienced similar conditions, so your compliance is absolutely important to your success.
- Should our facility need to contact you regarding appointment times or treatment, we will do so by calling the contact numbers you have provided. If necessary, a voice message will be left at these locations unless you provide written instructions otherwise.

Cancellations

Please allow 24-hour notice for Appointment Cancellations. Please notify us at (708) 598-9144 so we can fill the appointment with our Wait List Patients. A Missed Appointment charge equivalent to the visit fee will be billed if the minimal 24 hour advance cancellation notice is not provided.

Returned Products

- Pre-approval is required by Dr. Wright on all returns
- Refrigerated items CANNOT be returned
- No supplement returns will be accepted after 30 days on all regularly stocked items
- Special orders CANNOT be returned
- Prepaid labs can be returned for credit within one month of purchase

Lab Tests

- All labs are self-pay. A Lab Superbill will be provided in order for patients to submit to their insurance for possible reimbursement. A Superbill will be provided only if Lab is paid in full.
- If Lab Tests have been ordered, the results of your lab test(s) will be sent directly to Dr. Wright. If your Lab Results ARE NOT back in time for your next scheduled appointment, our office will call and reschedule your appointment.

Dear New Patient:

After you have read the above, please sign and return this page to our Front Desk.

Thank you ☺

I have read and understand Palos Chiropractic & Holistic Health'sNutritional Medicine Program Fee Schedule and Policies dated January, 2020.

Printed Name:

_____

_____

Signature Date

Guardian for: _____

NEW PATIENT HEALTH QUESTIONNAIRE

Name:				Date:
Address:				
City:		State:		Zip Code:
Phone	Home:	Cell: Cell Carrier: (Needed for Reminder Calls/Texts)		
E-mail:		NOTE: E-mail used for internal communications ONLY		
How did you find us / hear about us?				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Person responsible for this account:				
What is your MAJOR Complaint:				
Secondary, etc. Complaints:				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				
How much change are you willing to/able to make at this time to improve your health? (Please circle) Minimal Some Complete				

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Palos Chiropractic, Inc. to release my personal medical information to me.

Patient's Signature: _____ Date: _____.

PATIENT NAME: _____

PLEASE ANSWER ALL QUESTIONS FRANKLY & TO THE BEST OF YOUR KNOWLEDGE

1. If you are taking any medications and/or nutritional supplements, please list:

2. List Surgeries, starting with most recent:_____

_____

_____

3. List Hospitalizations:_____

_____

_____

4. If you have fillings, are they: ❑Amalgam (metals) ❑ Composite ❑ Combination of Both
❑ BEEN REMOVED

5. In the past, have you used □ Antibiotics? for how long: _____
□ Birth control pills for how long: _____

6. Do you presently, or have you ever had any of these conditions?

C = Currently PP = Present in Past

Anemia		Depression / Anxiety		Hypoglycemia		Thyroid Condition	
Arthritis		Diabetes		Kidney Problems		Unexplained Weight Change	
Asthma		Frequent Head-aches/Migraines		Liver Problems			
Chest Pains		Heartburn / Reflux		Osteoporosis			
Chronic Colds / Flu		High Blood Pressure		Skin Conditions			

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7. How much sleep do you get each night on average? _____ Hours

b) Do you regularly wakeup during the night? If so, roughly what time : _____

8. Do you have any food allergies, sensitivities or restrictions?

9. Do you ❑ SMOKE: If Yes, how much: _____

❑DRINK ALCOHOL : How much: _____

❑ ENERGY DRINKS: How much: _____

❑DRINK CAFFEINATED BEVERAGES: (coffee / energy drinks):
How much: _____ What type ? _____

❑ USE RECREATIONAL DRUGS: What type / How Often / For How Long ?
_____

10. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.):

_____

9. Are there foods that you eat on a daily basis?_____

_____

9a. Do you "miss"/crave these foods if you do not eat them? □ YES □ NO

10. Write briefly about your weight gain/loss history:_____

_____

a. What do you feel triggers your weight fluctuation? (circle) heredity stress eating habits boredom

b. Is your weight gain/loss: (circle) sudden gradual problem since childhood

11. What methods have you tried to lose/gain weight?_____

_____

_____

12. Please list close relatives that have diabetes, heart disease or obesity: _____

_____

13. How is your energy level? (0 = no energy 10 = high energy) _____

a. Are there times in the day that you feel best?_____worst?_____

14. Are you happy in your life right now? ❑ YES ❑ NO

15. What are your main sources of stress?_____

_____

16. How do you deal with your stress?_____

_____

17. Please answer the following questions Yes or No:

	YES	NO	N/A
If I'm feeling down a snack makes me feel better			
I sometimes have a hard time going to sleep without a bedtime snack			
I get tired and / or hungry in the mid-afternoon		Which?	
I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert.			
Now & then I think I am a secret eater			
At a restaurant, I almost always eat too much bread before the meal			
I have difficulty concentrating or frequent fuzzy or "spacey" thinking patterns			
I experience cravings for sugar, breads, pasta and baked goods			
I feel shaky if I don't eat on time or if I don't snack			
I often find myself irritable or angry			

18. Check off (✓) any of the following that have applied to you within the last 30 days:

_____Do you feel nauseous?	_____Do you have abdominal/intestinal pain?
_____Do you have bloating?	_____Do you get bloated after meals?
_____Do you get heartburn?	_____Do you have diarrhea?
_____Do you have constipation?	_____Do you travel outside of the U.S.?
_____Do you have gas?	_____Are your stools compact/hard to pass?
_____Do you belch following meals?	_____Do you have gurgles in your stomach?
_____Do your bowel movements alternate between constipation and diarrhea?	

19. In your estimation, how physically fit are you right now? (circle one)

Unfit Below average Average Above average Very fit

20. How often do you exercise? _____

a. What is your exercise regime? _____

21. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

_____

22. What are your fitness goals? (Check all that apply)

_____ General fitness endurance

_____ Weight loss/maintain weight

_____ Osteoporosis prevention

_____ Specific sport enhancement _____

_____ Flexibility

_____ Muscle toning

_____ Muscle strengthening

_____ Muscular coordination/balance

Other_____

_____

23. Briefly describe where you have lived since childhood:_____

_____

24. What is your heritage? (Polish, African American, Latin, etc.) _____

25. Circle NOW or PAST for only those items with which you identify. Ignore anything that does not apply to you.

Right now, Is your life:		Do you often:	
Satisfactory	Now Past	Feel depressed	Now Past
Boring	Now Past	Have anxiety	Now Past
Demanding	Now Past	Have irrational fears	Now Past
Unsatisfactory	Now Past		

Do you worry over:			
Home life	Now Past	Feel Upset	Now Past
Marriage	Now Past	Feel things go wrong often	Now Past
Children	Now Past	Feel Shy	Now Past
Job	Now Past	Cry	Now Past
Income	Now Past	Feel Inferior	Now Past
Money problems	Now Past	Have you: Seriously considered suicide?	Now Past

IMPORTANT!

Please fax / mail back these completed formsMINIMALLY One Day in Advance of your appt.

Fax: 708.301-4641 email: hspaloshills@gmail.com

CHIRO-MED Health Center
9441 W. 144th Place, Orland Park IL 60462
P: 708.598.9144
www.PalosChiro.com

Thank you–we are glad you're here – let your healing begin☺

BREAKFAST:

What time do you eat breakfast? _____
Do you eat it every day? ( ) Yes ( ) No

Give me (3) examples of breakfasts you would eat in a week (include beverages.)

1. _____
2. _____
3. _____

IN BETWEEN SNACK:
Do you eat a snack between breakfast & lunch, if so, give me two examples:

_____ _____

LUNCH:

What time do you eat lunch? _____
Do you eat it every day? ( ) Yes ( ) No

Give me (3) examples of lunches you would eat in a week (include beverages.)

4. _____
5. _____
6. _____

IN BETWEEN SNACK:
Do you eat a snack between lunch & dinner, if so, give me two examples:

_____ _____

DINNER:

What time do you eat dinner? _____
Do you eat it every day? ( ) Yes ( ) No

Give me (3) examples of dinners you would eat in a week (include beverages.)

1. _____
2. _____
3. _____

SNACK:
Do you eat a snack after dinner, if so, give me some examples:

_____ _____ _____