695 N Perryville Rd. Ste 1
Rockford, IL 61107
815-977-5480
815-977-3479
info@healingpathrockford.com
www.healingpathrockford.com

1. **Please enter your information.**

Today's Date _____ First Name: _____ Middle Initials: _____ Last Name: _____

Date of Birth: _____

Marital Status:
○ Single ○ Married
○ Domestic Partner
○ Separated ○ Divorced
○ Widowed

Gender:
○ Female ○ Male

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____

Email: _____

Preferred Contact Method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Spouse's Name/Occupation _____ Spouse's Date of Birth _____

Your Primary Care Provider/OBGYN/Midwife _____ Your Occupation _____

Your Employer _____ Insurance Carrier _____

Insured's Name (First, Last) _____ Insured's Employer _____

Who were you referred by? How did you hear about us? _____

2. **Please list your top major health concerns in order of importance, and indicate date of diagnosis (where relevant):**

	Concern	Date
1		
2		
3		
4		
5		

3. If you have seen other practitioners for your health issues (i.e., Chiropractor, Medical Doctor, Acupuncturist, Naturopath, Therapist, Homeopath, Massage Therapist, etc) please list and indicate the results of their evaluations.

4. Severity of pain?

0 - Not difficult / 10 - Unbearable

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

5. How does it impact your quality of life? What aren't you able to do or aren't able to do as well as you could before?

6. Describe your main complaint.

Is your condition work related?
○ Yes ○ No

Are you currently having discomfort or pain?
○ Yes ○ No

Do you know the cause of the pain?

How often is the complaint present? (e.g. constant, comes and goes, infrequent)

Does anything aggravate the pain?

Does anything relieve the pain?

Can you describe the pain? (e.g. tingling, numbness, burning, radiating, sharp, spasming, sore, dull, achy...)

Where do you hold stress in your body?

7. Cardiovascular

- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Cold feet
- ☐ Edema
- ☐ Heart disease
- ☐ High/Low blood pressure
- ☐ High/Low Cholesterol
- ☐ Pace maker
- ☐ Poor circulation
- ☐ Rapid/Irregular pulse
- ☐ Rheumatic fever
- ☐ Stroke/TIA
- ☐ Swelling
- ☐ Varicose veins
- ☐ Other

If "other", or "edema", please specify.

8. Digestive

- ☐ Acid Reflux
- ☐ Anorexia/bulimia
- ☐ Bloating
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Diarrhea
- ☐ Heart burn
- ☐ Irritable bowel syndrome
- ☐ Nausea
- ☐ Ulcer
- ☐ Other

If "other", please specify

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9. Endocrine

- ☐ Fainting
- ☐ Fatigue
- ☐ Frequent infections
- ☐ Hypoglycemia
- ☐ Immune Disorders
- ☐ Poor appetite
- ☐ Swollen glands
- ☐ Thyroid Disorder
- ☐ Weight gain/loss
- ☐ Other

If "other", please specify

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10. Genitourinary

- ☐ Bedwetting
- ☐ Bladder infection
- ☐ Incontinence
- ☐ Kidney disorder
- ☐ Prostate Disorder
- ☐ Other

If "other", please specify

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11. Muscle / Joint / Bone

- ☐ Arthritis
- ☐ Headaches
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Shoulder/Elbow/Wrist/Hand pain
- ☐ Hip/Knee/Ankle/Foot pain
- ☐ Muscle weakness
- ☐ Osteoporosis
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ TMJ Disorders
- ☐ Other

If "other", please specify. If "Arthritis", specify location.

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12. Neurological

- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Migraine
- ☐ Seizures
- ☐ Other

If "other", please specify

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13. Respiratory

- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Poor Sleep
- ☐ Sleep Apnea
- ☐ Other

If "other", please specify

_____

14. Sensory

- ☐ Blurred Vision
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Ear infections
- ☐ Loss of smell
- ☐ Other

If "other", please specify

_____

15. Skin

- ☐ Acne
- ☐ Bruise easily
- ☐ Eczema
- ☐ Hair loss
- ☐ Hives / Rash
- ☐ Psoriasis
- ☐ Other

If "other", please specify

_____

16. Systemic Disorders

- ☐ Cancer
- ☐ Diabetes (Type?)
- ☐ Fibromyalgia
- ☐ HIV/AIDS
- ☐ Post Polio Syndrome
- ☐ Other

If you checked yes to: cancer, diabetes and/or other: - please specify

_____

17. Women

- ☐ Breast conditions
- ☐ Cysts
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hysterectomy
- ☐ Infertility
- ☐ Irregular periods
- ☐ Menopause
- ☐ Menstruation
- ☐ Peri/Postmenopausal
- ☐ PMS symptoms
- ☐ Pregnant. How far along?
- ☐ Other

If "other", please specify

_____

18. Please fill in as appropriate:

	Child	Father	Mother	Brother(s)	Sister(s)	Spouse	Other (specify)
Age (if living)							
Age (at death)							
Cause of death							
Anemia							
Cancer							
Diabetes							
Epilesy							
Glaucoma							
Heart disease							
High blood pressure							
Hay fever							
Hives							
Kidney disease							
Mental illness							
Rheumatoid arthritis							
Tuberculosis							
Syphilis							
Stroke							
Other (specify)							

19. Please list any non-prescribed medications you take (laxatives, antihistamines, decongestants, aspirin, tylenol, etc.):

	Type	How Often?
1		
2		
3		
4		
5		

20. **Please list any prescribed medications you take:**

	Name	Dosage	How long?
1			
2			
3			
4			
5			
6			
7			

21. **Supplements now or in the recent past:**

	Name of supplement	Dosage	Benefits
1			
2			
3			
4			
5			

22. **Any accidents, injuries, fractures or surgeries you have had?**

More than 5 years ago:

Less than 5 years ago:

23. **Do you sit for long hours at a workstation, computer, or driving? If yes, please describe your work conditions. (e.g. standing desk, ergonomic chair, eye level computer placement, long drives, etc...)**

24. **Habits and Lifestyle**

Do you smoke? ○ Yes ○ No — How much per day? — Since when?

Do you drink alcohol? ○ Yes ○ No — How much? — How often?

Do you drink soda pop? ○ Yes ○ No — If yes, what type? ○ Regular ○ Diet — How much?

Do you exercise regularly?
○ Yes ○ No

If yes, please describe what you do.

How much water do you drink daily?

How many pain relievers do you take daily/weekly?

25. **Emotional stress scale**

0 - No stress / 10 - Extremely stressed:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

26. **How many hours sleep a night do you get on average?**

27. **Do you have any problems getting to sleep? (e.g.: worrying about things, mind won't switch off, stress and anxiety)?**

28. **Do you have any problems staying asleep (e.g.: need to go to the toilet, no reason you wake up, baby wakes you)?**

29. **What would you like to be able to do again that you can't now or are having difficulty doing now?**

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Acknowledgement of Insurance Billing

Your insurance company has declared that in order to be eligible for chiropractic coverage, medical necessity must be shown for any treatment and our office does that through performing an initial examination. In compliance with this requirement, your exam will be submitted to your insurance company by Healing Path of Rockford. Any discount or promotion regarding your exam is at the agreement of you and Healing Path of Rockford and will not negate the submission of claims to your insurance company.

☐ I understand that my insurance company mandates I receive an examination to allow me to be eligible for future chiropractic coverage for treatment received at Healing Path of Rockford.

☐ I understand that any claims regarding my examination will be submitted to my insurance company regardless of a new examination promotion or discount offered by Healing Path of Rockford.

☐ I understand that I may not contest the claims sent to my insurance company regarding my examination at Healing Path of Rockford.

☐ I understand that any insurance benefit received by Healing Path of Rockford for my examination will not be applied as a credit on my account or eligible as a patient credit/refund.

☐ I understand that regardless of the specific coverage provided by my insurance company for my examination, Healing Path of Rockford will honor any discount or promotion offered for compensation of my examination.

☐ I understand I am responsible for any initial examination charges not included in my care plan (if applicable).

Today's Date

_____

_____ _____

Client Signature Date

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Authorization to Release Information

I, _____, give permission to Healing Path of Rockford to release verbal and/or written information regarding my care to my:

- ☐ Spouse _____
- ☐ Child _____
- ☐ Parent _____
- ☐ Representative _____
- ☐ Information is not to be released to anyone

I understand that this can be revoked or modified at any time through written communication with Healing Path of Rockford.

Today's Date

_____

_____ _____

Client Signature Date