ANTIOCH CHIROPRACTIC CENTER

"Better health for your family the natural way"

Dr. James G. Cross, D.C.
Chiropractic Physician
311 West Depot Street, Suite L
Antioch, IL 60002-1500
Telephone: (224) 788-9949
Fax: (224) 788-9950
Dr.Cross_Notes@aol.com

Name _____ Date _____ File No _____
First Middle Initial Last

Address_____ Email_____

City_____ State_____ Zip_____ Phone: H:_____

Birth Date_____ Last 4 digits of SSN#_____ Cell:_____

Marital Status S M W D Number of Children_____ Occupation _____

Employer_____ Address _____

City_____ State_____ Zip_____ Phone_____

Hobbies, Clubs, Organizations, Special Interests_____

Insured's Name/Guardian's Name_____ Last 4 Digits of SSN_____ DOB_____

Address_____ City_____ State____ Zip_____ Phone_____

Emergency Contact Person_____ Phone# H / C _____

Address_____ City_____ State_____ Zip_____

Primary Care Physician_____ City_____ State_____ Phone_____

Date of Last Physical Exam_____ Examiner_____

Reason For Today's Visit_____

Date of Injury / Onset of Symptoms_____ Cause of Injury /Symptoms_____

Other Doctors Seen for this condition_____

FEMALE PATIENTS: ARE YOU PREGNANT AT THIS TIME YES NO

PAYMENT OR CO-PAY IS EXPECTED AT TIME OF VISIT

Name of Person Responsible For Payment: _____

I understand that the Antioch Chiropractic Center will prepare any necessary forms to assist me in making collection from the insurance company and that any amount received will be applied to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree to be responsible for any late payment penalties or interest charges due to my failure to pay for services rendered on a monthly basis and agree to pay for any attorney fees and court costs incurred if legal action is necessary in order to collect any unpaid balance on my account. Penalty or interest charges are not to exceed 1 ½ % per month or as specified by statue, and attorney fees are to be those which are reasonable and customary. I am fully aware that any x-rays performed by or by the order of Antioch Chiropractic Center are part of my personal health record and will be part of my permanent records at Antioch Chiropractic Center, loaned to me as necessary, but are to be returned to Antioch Chiropractic Center after being reviewed by other providers.

Patient's Signature_____ Date_____

Guardian or Spouse's Signature_____ Date_____

IF YOUR INJURY IS DUE TO AN ACCIDENTAL INJURY PLEASE COMPLETE THE QUESTIONS ON THE BACK OF THIS SHEET

Date of Injury_____ Time_____am /pm Location_____
How did injury occur? Auto crash_____ On-the-job injury_____ Other_____
Please describe how this happened_____

_____

If on the job injury, did you report this to your employer? Yes No
Name of supervisor_____ Phone #_____
If auto crash, were you Driver_____ Passenger_____ Pedestrian_____
If an auto crash, were you struck from behind_____ front_____ right side_____ left side_____
Did your car strike the other car Yes_____ No_____ OR Did the other car strike yours Yes_____ No_____
Were you aware of the impending crash Yes_____ No_____
What was your position at the point of impact Looking straight forward____ Looking to the left____
Looking up_____ Looking down____Looking to the right____ Bending to the left____
Bending to the right____ Other (please explain)_____

_____

As a result of the crash, were traffic citations issued to you Yes No
Were citations issued to the other driver Yes No
List the injuries you feel or were told you sustained_____

_____

Did you require post crash hospitalization Yes No If yes, what hospital and how long were you in the hospital_____

PLEASE CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH:

___HEADACHE ____IRRITABILITY ____NUMBNESS IN ARMS OR LEGS ____FLUSHED FACE ____FATIGUE

____NECK PAIN ____CHEST PAIN SHORTNESS OF BREATH ____RINGING IN EARS ____DIZZINESS

____STIFF NECK ____LOSS OF BALANCE ____SLEEPING PROBLEMS ____PINS AND NEEDLES IN ARMS OR LEGS

____LIGHTS BOTHER THE EYES ____LOSS OF SENSE OF SMELL ____NERVOUSNESS ____TENSION

____MEMORY LOSS ____LOSS OF TASTE ____DIARRHEA ____CONSTIPATION ____FEVER

____UPSET STOMACH ____COLD SWEATS ____OTHER, IF SO PLEASE LIST_____

_____

Have you lost any days of work? If so, please provide dates_____

_____

MY INSURANCE COMPANY_____ Policy#_____
PHONE#_____ ADJUSTER'S NAME_____

OTHER DRIVER'S INSURANCE COMPANY_____ PHONE#_____

YOUR ATTORNEY'S NAME, LOCATION AND PHONE# IF YOU HAVE ONE FOR THIS CASE_____

_____

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Patient Name _____ Date_____ File #_____

ACTIVITIES OF DAILY LIVING: HOW WELL CAN YOU DO THE FOLLOWING; PLEASE CIRCLE THE APPROPRIATE NUMBER AFTER THE ACTIVITY

0= ESSENTIALLY NORMAL, NO HELP NEEDED 10= UNABLE TO PERFORM

A. SLEEPING – 0 1 2 3 4 5 6 7 8 9 10

B. GETTING OUT OF BED- 0 1 2 3 4 5 6 7 8 9 10

C. SITTING- 0 1 2 3 4 5 6 7 8 9 10

D. CLIMBING STAIRS- 0 1 2 3 4 5 6 7 8 9 10

E. STANDING- 0 1 2 3 4 5 6 7 8 9 10

F. WALKING- 0 1 2 3 4 5 6 7 8 9 10

G. DRESSING- 0 1 2 3 4 5 6 7 8 9 10

H. LAYING DOWN- 0 1 2 3 4 5 6 7 8 9 10

I. BENDING- 0 1 2 3 4 5 6 7 8 9 10

J. ENTERING OR EXITING A CAR- 0 1 2 3 4 5 6 7 8 9 10

K. ANY OTHER ACTIVITY NOT LISTED, PLEASE LIST AND PROVIDE A THE NUMBER THAT INDICATES THE DEGREE OF DIFFICULTY IN PERFORMING

_____

_____

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PATIENT NAME_____ DATE_____ FILE_____

MEDICAL AND HEALTH HISTORY MH – 1 PAGE ONE

MEDICATIONS-PLEASE LIST	PURPOSE	DOCTOR WHO PRESCRIBED

PLEASE CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD AND THE YEAR IF KNOWN

DISEASE	CHECK	YEAR	DISEASE	CHECK	YEAR
CHI CKEN POX			PNEUMONIA		
DIPHTHERIA			POLIO		
ENCEPHALITIS			RHEUMATIC FEVER		
GERMAN MEASLES			TUBERCULOSIS		
MALARIA			THPHOID		
MEASLES			VENERAL DISEASE		
MENINGITIS			WHOOPING COUGH		
MMPS			OTHER		

HAVE YOU EVER HAD ANY REACTION OF SIDE EFFECTS FROM DRUGS, VACCINES, CHEMICALS OR OTHER AGENTS?

YES NO IF YES, PLEASE EXPLAIN _____

_____

YES NO DO YOU HABITUALLY USE LAXATIVES? HOW LONG?_____

YES NO DO YOU USE ALCOHOL HOW MUCH?_____ # OF YEARS _____

YES NO DO YOU USE TOBACCO HOW MUCH?_____ # OF YEARS _____

YES NO DO YOU USE NARCOTICS /OPOIDS? NAME _____

YES NO HAVE YOU EVER LIVED IN A FOREIGN COUNTRY? NAME_____

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MEDICAL AND HEALTH HISTORY – CONTINUED

PATIENT NAME_____ DATE_____ FILE_____

PLEASE CIRCLE ANY OF THE FOLLOWING OPERATIONS YOU HAVE HAD AND GIVE THE DATE OF SURGERY

AREA	REASON	DATE
BLOOD VESSEL		
BONE		
BOWEL		
BREAST		
CANCER – TYPE AND LOCATION		
CHEST		
EYE		
GALL BLADDER		
HEART		
HEMORRHOIDS OR RECTAL		
HERNIA - ABDOMINAL OR INGUINAL		
JOINT – WHICH AND WHAT SIDE		
PROSTATE		
SPINE – AREA:		
STONES – KIDNEY		
TUMOR OF ANY KIND		
THYROID		
VARICOSE VEINS		
OTHER		
OTHER		

FAMILY HISTORY: HAVE YOUR GRANDPARENTS, PARENTS, UNCLES OR AUNTS, BROTHERS OR SISTERS, NIECES OR NEPHEWS OR CHILDREN EVER BEEN TREATED FOR: (PLEASE CIRCLE YES OR NO)

		CONDITION	RELATIONSHIP
YES	NO	BLEEDING DISORDER	
YES	NO	BLOOD DISORDER OR ANEMIA	
YES	NO	CANCER	
YES	NO	DIABETES	
YES	NO	EMPHYSEMA OR OTHER COPD	
YES	NO	EPILEPSY	
YES	NO	GLAUCOMA	
YES	NO	GOUT	
YES	NO	HAY FEVER OR ASTHMA	
YES	NO	HEART DISEASE	
YES	NO	HIGH BLOOD PRESSURE	
YES	NO	KIDNEY DISEASE	
YES	NO	LIVER DISEASE	
YES	NO	NERVOUS BREAKDOWN	
YES	NO	NERVOUS OR MUSCULAR DISORDER	
YES	NO	RHEUMATIC FEVER	
YES	NO	SEVERE DEAFNESS	
YES	NO	TUBERCULOSIS	
YES	NO	ULCERS	

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MEDICAL AND HEALTH HISTORY – CONTINUED

PATIENT NAME_____ DATE_____ FILE_____

FOR ANY CONDITION LISTED BELOW THAT **YOU** HAVE EVER HAD, PLEASE CIRCLE IT AND GIVE THE DATE IF KNOWN

CONDITION	DATE	CONDITION	DATE
ANEMIA OR OTHER BLOOD DISORDER		PINCHED NERVE	
BLEEDING EASILY		NECK PROBLEMS	
BRUISING FREQUENTLY		BACK PROBLEMS	
HEART TROUBLE OF ANY TYPE		SCOLIOSIS	
CHEST PAIN OR DISCOMFORT		ARM PROBLEMS	
HIGH BLOOD PRESSURE		LEG PROBLEMS	
VARICOSE VEINS		BROKEN BONES	
FAINTING OR DIZZY SPELLS		ARTHRITIS	
DIABETES – TYPE ONE OR TYPE TWO PLEASE CIRCLE WHICH		THYROID PROBLEMS	
SUDDEN WEAKNESS		SERIOUS INFECTIONS	
ASTHMA		SWOLLEN GLANDS	
EMPHSEMA OR OTHER COPD		INSOMNIA	
ALLERGIES		NERVOUS BREAKDOWN	
HEADACHE, SEVERE OR FREQUENT		EMOTIONAL PROBLEMS	
HEAD INJURIES		TUMOR OF ANY KIND	
SINUS PROBLEMS		CANCER	
INTESTINAL PROBLEMS INCLUDING CHRONIC CONSTIPATION OR DIARRHEA		SKIN DISEASE	
HERNIA – INGUINAL, ABDOMINAL OR HIATAL – PLEASE CIRCLE WHICH		FREQUENT TOOTHACHES OR GUM TROUBLE	
PARALYSIS		EAR INFECTION	
PLEURISY		EYE INJURY OR DISEASE	
PERSISTENT COUGH		ULCER – STOMACH OR INTESTINE	
COUGH UP BLOOD		ABDOMINAL PAIN – FREQUENT OR SEVERE	
KIDNEY DISEASE OR STONES		MENSTRUAL PROBLEMS	
BLADDER PROBLEMS / INFECTIONS		ON BIRTH CONTROL PILLS	
GALLBLADDER TROUBLE		RECTUM PROBLEMS	
HEPATITIS OR OTHER LIVER PROBLEMS		HEMORRHOIDS	
EPILEPSY		OTHER	
HEARING DIFFICULTY		OTHER	

	ALIVE	DECEASED	AGE	CAUSE OF DEATH
MOTHER				
FATHER				

PLEASE LIST ANY OTHER HEALTH CONCERNS YOU HAVE THAT ARE NOT LISTED ABOVE OR YOU WOULD LIKE TO DISCUSS.