▲ CONFIDENTIAL PATIENT INFORMATION ▲

PATIENT INFORMATION

Date ______
Name ________________________________ Age _____
Birthdate ___________ Height _______ Weight ______
Address ____
City ____________________ State______ Zip _______
Phone _________________ Cell ___________________
Work ___________________ E-Mail _______________
SS# ____

□ **Single** □ **Married** □ **Widowed** □ **Separated** □ **Divorced**

Occupation:________________________________
Employer: ________________________________
Employer Address: __________________________
City_____________ **State**_____ **Phone:**________________
Spouse's/Partner's Name ___________________________
Birthdate _________________ **SS#**____________________
Occupation ____
Employer:____
In case of an emergency whom may we contact? __________
_________________________ **Phone** __________________
Cell ______________________ **Work** _________________
Whom may we thank for referring you? ________________

INSURANCE

Who is responsible for this account? _________________
Relationship to Patient ____________________________
Insurance Company _______________________________
Group # ______________________________________
Is the patient covered by additional insurance? □ **YES** □**NO**
Subscriber's Name ________________________________
Birthdate __________ SS#_____________________
Relationship to Patient ____________________________
Insurance Co. ___________________________________
Group # ______________________________________

Patient Social History

Exercise	Work Activity	Habits
__None	__ Sitting	__ Smoking
__Moderate	__ Standing	__ Alcohol
__ Daily	__ Light Labor	__ Coffee-Caffeine
__ Heavy	__ Heavy Labor	__ High Stress Level

Notes: ____
____

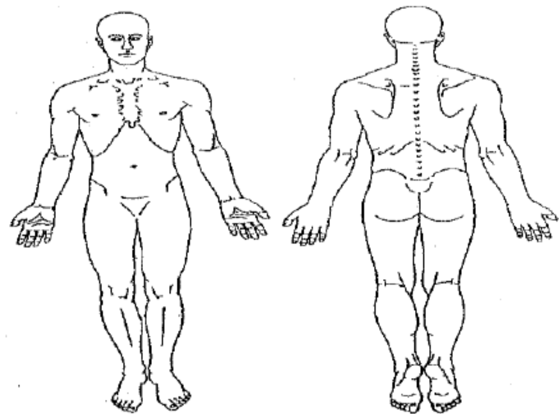
PATIENT CONDITION

Reason For Visit ________________________________
____
When did Your Problem Begin? □ Job Injury/Date ______
□ **Work Injury/Date** __________ □ **Other/Date** __________
Have you had this problem previously □ **Yes** □ **No**
When?______________________________________
Is the pain constant or comes and goes? _______________
What concerns you most about your condition?__________
____
Does it interfere with your □ **Work** □ **Sleep** □ **Daily Routine** □ **Recreation**

Have you been given a named diagnosis for your condition?
□ **Yes** □ **No** **Name**_______________________________
Have you had treatment for this condition? □ **Yes** □ **No**
When? __________________ Results? _______________
____
Doctor Who Treated You? □ **Chiropractor** □ **Medical Doc** □ **Acupuncturist** □ **Physical Therapy** □ **Other**
Doctor's Name, Address, and Phone __________________
____

Patient Condition (Cont.)

Mark an "X" on the Diagram Below Where your Pain is:



Describe your pain: □ **Achy** □ **Burning**□ **Cramping** □**Dull** □ **Electrical Shock** □**Numbness** □ **Radiating** □ **Sharp** □ **Shooting** □ **Stabbing** □ **Stiffness** □ **Swelling** □ **Throbbing** □ **Tingling**
Rate pain on scale of 1 (least)-10 (worst) (refer to chart) _____
The Pain: □ **Wakes me up at night** □ **is getting worse** □ **is staying the same** □**comes and goes** □ **is worse in the morning** □ **worsens with sexual activity** □ **is better in the morning** □ **is worse at the end of the day** □ **worsens with changes in the weather** □ **is constant** □ **is getting better on its own.**

Affects on Lifestyle (check all that apply)

You:
- _ Interrupted Sleep
- _ Nervousness
- _ Hinders Recreation Activity
- _ Trouble Sleeping
- _ Irritable

At Work:
- _ Not as Productive
- _ Hinders Decisions
- _ Poorer Attitude
- _ Can't work Long Hours
- _ Sleepy at Work

Other (problems) :
- _ Driving a motor vehicle
- _ Sitting in a motor vehicle
- _ Exercising
- _ Sporting Activities
- _ Climbing Stairs
- _ Carrying Purse/Briefcase
- _ Lifting objects (Heavy/Light)

Family/Friends:
- _ Losing patience w/spouse
- _ Losing patience w/ kids

Activities (difficulty with):
- _ Standing
- _ Walking
- _ Bending Back
- _ Bending Forward
- _ Bending Left
- _ Bending Right
- _Twisting Left
- _ Twisting Right
- _ Sitting
- _ Reaching

Health History

PAST HISTORY

List any significant injuries, surgeries, fractures, hospitalizations Major dental work, medical conditions:

Description	Date	Treatment

FAMILY HISTORY (check "Y" If you have had "F" family)

___ Allergy ___Diabetes___ Kidney Disease ___Polio
___Anemia ___ Eczema ___ Lung Disease ___ Pleurisy
___ Arthritis ___ Epilepsy ___ Mental Illness___ Pneumonia
___ Asthma ___ Gout ___ Measles ___ Rheumatic fv
___Cancer ___ Heart Dis.____ Migraines ____ Small Pox
___ Chk Pox ___ Influenza ____ Mumps ____ Spinal Dis.
__Thyroid Problems __Tonsillitis __Tuberculosis __ Ulcers
Other: __ AIDS/HIV __Alcoholism ___Stress/Anxiety
---Drug Abuse __ Hepatitis __ Colon Disease __High BP
____ Low Blood Pressure ___ Depression

Review Of Systems

p= past c=current s= severity 1-10

p	c	s	General Symptons	p	c	s	Heart Conditions
			Headaches				Hardening of Artery
			Fever				High Blood Press
			Chills				Pain over heart
			Numbness				Paralytic Stroke
			Fainting				Poor Circulation
			Dizziness				Previous Stroke
			Convulsions				Rapid Heart Beat
			Shortness of Breath				Slow Heart Beat
			Fatigue				Swollen Ankles
			Facial Pain				Varicose Veins
			Night/Cold Sweats				Gastro-Intestinal
			Wheezing				Poor Appetite
			Loss of Taste				Poor Digestion
			Loss of Balance				Constipation
			Loss of Memory				Diarrhea
			Loss of Sleep				Distended Abdomen
			Loss of Smell				Excessive Hunger
			Depression				Liver Problems
			Confusion				Weight Gain/Loss
			Twitching				Colon Trouble
			Tremors				Belching or Gas
p	c	s	Skin Problems	p	c	s	Skin Problems
			Boils				Hives or Allergies
			Bruises				Itching
			Dryness				Skin Eruptions

Review of Systems (Cont)

p	c	s	EENT	p	c	s	Muscles/Joints
			Vision Problems				Low Back Pain
			Crossed Eyes				Weakness
			Pain behind eyes				Hip Pain
			Deafness				Neck Pain
			Hearing Loss				Backache
			Ear Discharge				Shoulder Pain
			Ear Infections/aches				Wrist/Hand Pain
			Nasal Obstruction				Foot/Ankle Pain
			Nose Bleeds				Tail Bone Pain
			Sore Throat				Spinal Curvature
			Hoarseness				Mid Back Pain
			Hay Fever				Elbow Pain L/R
			Enlarged Thyroid				Knee Pain L/R
			Sinus Infections				Genito-Urinary
			Gum Trouble				Frequent Urination
			Frequent Colds				Blood in Urine
			Eye Pain				Kidney Infection
			Ringing in Ears				Kidney Stones
			RESPIRATORY				Prostate Trouble
			Lung Problems				Bed Wetting
			Chronic Cough				
p	c	s	Women's Issues	p	c	s	Women's Issues
			Menstrual Cramps				Excessive Flow
			Menstrual Backache				Hot Flashes
			Premenstrual Tension				Irregular Cycle

Referring to the above table, which of these symptoms concern you most? ______________________________

____

ALLERGIES: To Foods, Medications, Other:

____

____

CURRENT MEDICATIONS: (Prescription/Non-prescription and reasons for taking)

____

____

CURRENT SUPPLEMENTS (Vitamins, Herbs, Homeopathics, and reasons for taking them)

____

____

HEALTH GOALS (Please list what you wish to accomplish through chiropractic care)

____

____

HIPAA Notice of Privacy Practices

Windy City Wellness S.C. 1811 W North Ave Suite 202, IL 60622
847-754-1946

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review it Carefully.

This Notice of Privacy and Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the chiropractor's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed , to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health care information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to chiropractic students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose you protected health information, as necessary, to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases: Health oversight: Abuse or neglect: Food and drug administration requirements: Legal proceedings: Law enforcement: Coroners: Funeral Directors, and organ donation: Research: Criminal activity: Military activity and national security: Workers" compensation: Inmates: Required uses and disclosures: Under the law, we must make disclosures to you when required by the secretary of the department of health and human services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractor's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health care information not be disclosed to family members or friends who may be involved with your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you may request. If chiropractor believes it is in your best interest to permit the use and disclosure or your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively ie. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health care information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of , and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:____________________ Signature__________________________ Date______

▲ INFORMED CONSENT ▲

Please Read and Sign:

I hereby authorize Dr. Pontarelli and the staff at Windy City Wellness to treat my condition as deemed appropriate. I also authorize Dr. Pontarelli and the qualified practitioners at Windy City Wellness to perform examinations, chiropractic adjustments, physiotherapy, muscle work, massage, the procedures within Chiropractic Plus Kinesiology and Applied Kinesiology, and Scenar Therapy in my treatment plan to for optimal health. I know that all the recommendations he makes are intended to promote my optimal health and are not to be misconstrued as prescriptions that treat disease. I will have the opportunity to ask questions about the nature and purpose of such procedures, possible risks, and alternative procedures. I have the right to refuse any procedure.

I understand that Dr. Pontarelli will prepare any necessary reports and forms to assist me in collection from any insurance company or attorney involved in my claim, and I authorize the release of any and all health information, treatment records, and the prognosis of my condition to my employer, attorney, or any insurance company involved.

I understand and agree that health and accident insurance policies are and arrangement between an insurance carrier and myself. I understand that any amount authorized to be paid directly to Windy City Wellness will be credited to my account upon receipt. I also clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand and agree that if I suspend or terminate my care and treatment, any fees for care rendered me will be immediately due and payable. . I will be responsible for any costs of collection, attorney's fees, or court costs required to collect my bill.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, Windy City Wellness cannot promise a cure for any symptom, condition, or disease as a result of treatment in the clinic. An attempt to provide me with the very best care is their goal and if the results are not acceptable, they will refer me to another provider who they feel can further assist me.

Specific Risk Possibilities Associated with Chiropractic Care
Soreness- Chiropractic adjustments and rehab procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally, chiropractic treatment may aggravate a disc injury or cause other minor joint, ligament, tendon, or other soft tissue injury.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No.2, June, 1993) estimate that the incidence of this type is one in every three million upper cervical adjustments.

Any other types of side effects should be reported to your doctor promptly.

Having carefully read the above and the policies and procedures of Windy City Wellness, I hereby give my informed consent to have chiropractic treatment administered.

____

Patient Signature   Printed Name   Date

____

Parent/Legal Guardian Signature   Printed Name   Date