CHICAGO CONSERVATIVE CARE

PATIENT INFORMATION *(Please Print in Ink)*

If you have any questions or concerns do not hesitate to ask/call for assistance, we will be happy to help you.

Name _____ Date of Birth ____ /____ /____ Age _____ □ Female □ Male

Address _____ Unit _____ City _____ State _____ Zip _____

Best Phone # _____ Email (for appt. reminders)_____

Height _____ Weight _____ Occupation _____ Date Symptoms Began _____

Emergency Contact _____ Emergency Contact Phone # _____

How did you find us? □ Google □ Yelp □ Walk-In □ ZocDoc □ Insurance List □ Referred By:_____

INSURANCE INFORMATION - *please present card to front desk*

Insurance _____ ID/Policy # _____ Group # _____

CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. The most common side-effects are of short duration and include local discomfort in the area of treatment, pain, and muscle soreness. The scientific literature suggests that serious events such as stroke are extremely rare, and that chiropractic treatment is safe.

FINANCIAL RESPONSIBILITY

Payment for services is due at the time services are rendered unless other arrangements have been approved by our staff. If you have a co-pay, we will accept that until we have received notice or payment form your insurance company. Your claims will be filed by us as a courtesy for in-network policies only. Your insurance is an agreement between you and your insurance company, and you are responsible for knowing your eligibility and details of coverage.

Our fees fall within the usual, customary, and reasonable charges for this region. Not all insurance plans will pay for all services performed at this office. Any unpaid balance not paid by insurance is the patient's responsibility. The credit card on file will be utilized if the patient responsibility portion of your charges are not paid in full within 30 days. I fully understand that I am ultimately responsible for the balance of my account for any services rendered.

CANCELATION/LATE APPOINTMENT COMMITMENT

We are dedicated providers that take our commitment to deliver needed healthcare services to our patients in a time-sensitive manner earnestly. As a result, it is essential that appointment times are taken seriously by all patients. We ask for at least 24 hours' notice for changing existing appointments and reserve the right to cancel your appointment if you are running late and our schedule cannot accommodate the change. A $60 fee will be applied to your credit card on file if we are unable to book your late-cancel appointment with another patient. Additional fees may apply to other missed services booked with your doctor visit.

Please note that after 2 last minute cancelled appointments, you will be asked to schedule appointments outside of our high demand periods until your appointment status is back in good standing. It is not our goal to charge additional fees, but we do feel it is our responsibility to show respect to our patient's time and schedules, including yours. We take pride in making our patients feel well cared for and valued!

AUTHORIZATION

I understand that providing incorrect or incomplete information on intake forms can be dangerous to my heath. I authorize the facility to release any information including diagnosis, records, treatment, and examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to directly pay the billing provider or facility. I certify that I have read and understand the above information to the best of my knowledge.

X_____ ____ /____ /____

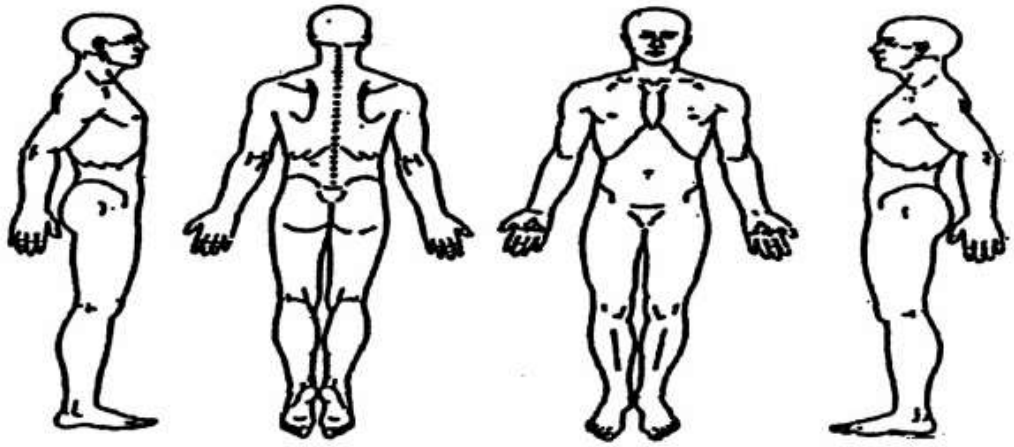
Signature of Patient (or parent if a minor) Date

(773) 697-8088 PHONE • (888) 404-8086 FAX
1706 W NORTH AVE, CHICAGO, IL 60622

Name _____ **Date of Birth** ____ /____ /____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms:



3. How often do you experience this pain/symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

(Please circle) 0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____ **Have you had previous episodes?** □ No □ Yes

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What makes your problem worse? Position? Activity? Morning vs. Evening?

_____

14. What makes your problem better? Position? Activity? Morning vs. Evening?

_____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. What is your: Height_____ **Weight** _____lbs **Date of Birth** ____ /____ /____

17. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

20. For each condition, check "past" column (if previous issue) or check "present" column (if current issue)

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ Chronic Sinusitis	□	□ Dizziness
□	□ Neck Pain	□	□ High Blood Pressure	□	□ Diabetes
□	□ Upper Back Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Mid Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Low Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Shoulder Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Elbow/Upper Arm Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Wrist Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Hand Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Epilepsy
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ Dermatitis/Eczema/Rash
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ HIV/AIDS
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Other:_____
□	□ Cancer	□	□ General Fatigue	□	□ Other:_____
□	□ Tumor	□	□ Muscular Incoordination	□	□ Other:_____
□	□ Asthma	□	□ Visual Disturbances		

21. List all prescription medications you are currently taking:

_____

22. List all the over-the-counter medications/supplements/vitamins you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

25. What activities do you do outside of work?

_____

26. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

27. Have you seen another chiropractor physician for this problem? □ No □ Yes

if yes, how long ago_____ did it improve your problem? □ No □ Yes

28. Have you ever had a serious injury? □ No □ Yes: **Date & Describe**_____

29. Anything else pertinent to your visit today?_____

X_____ ___ /___ /___

Signature of Patient (or parent if a minor) Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.