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 (appointment reminders) ___________________________________

Height ________ Weight ________ Occupation _____________________ Date Symptoms Began___________

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Emergency Contact ______________________________ Emergency Contact Phone # _____________________

How did you find us? ☐ Google ☐ Yelp ☐ Walk-In ☐ Groupon ☐ Insurance Provider List ☐ Referred By:______________

INSURANCE INFORMATION

Primary - *please present card to front desk*

Insurance ____________________ Primary Insured Name ______________ Relation to You ______________

ID/Policy # ____________________________ Group # ____________________

Secondary - *please present card to front desk*

Insurance ____________________ Primary Insured Name ______________ Relation to You ______________

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 rare and that chiropractic is safe.

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my heath. I authorize the chiropractor to release any information including diagnosis, records, treatment and examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to directly pay the chiropractor for chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered to me or my dependents.

X____ ____ /____ /____

Signature of Patient (or parent if a minor) Date

FINANCIAL RESPONSIBILITY

Payment for services is due at the time services are rendered unless other arrangements have been approved in advance 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. You realize that your insurance is an agreement between you and your insurance company.

Our fees normally fall with the UCR which is defined as 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. I fully understand this agreement between this office and myself. I am ultimately responsible for the balance of my account for any services rendered.

X____ ____ /____ /____

Signature of Patient (or parent if a minor) Date

PURPOSE FOR THIS VISIT:

What is the reason for contacting us?____

How long has the child experienced this? _______________________________________

Is it getting better or worse over time? ____

Have you tried anything for this complaint?_____________________________________

Have you seen any other health professionals for this? Yes_____ No_____

Are you content with your child's present level of health? Yes_____ No_____

Does your child eat junk food? Yes_____ No_____

Does your child exercise? Yes_____ No_____

SYSTEM REVIEW OF THE INFANT/CHILD: Please Circle- YES or NO

1. Has you child experienced weight changes, low energy or recent fever? **YES NO**
2. Skin: Any skin trouble such as rashes, bleeding, dryness, lumps? **YES NO**
3. Head: Any headaches, head injuries, dizziness or balance problems? **YES NO**
4. Eyes: Vision disorders, pain, redness, excessive tearing or glasses/contacts? **YES NO**
5. Ears: Any hearing disorders, infections, ringing in ears or discharge? **YES NO**
6. Nose and sinuses: Frequent colds, nasal stuffiness, sinus trouble or drainage? **YES NO**
7. Mouth and throat: Sore throat, dental trouble, speech trouble or sore tongue? **YES NO**
8. Lymphatics: Enlarged and/or painful lymph nodes? **YES NO**
9. Neck: Lumps/masses, pain, or swollen glands? **YES NO**
10. Breasts: Pain, discharge, masses or asymmetry? **YES NO**
11. Respiratory: Cough, difficulty breathing, frequent colds, allergies or asthma? **YES NO**
12. Cardiovasular: Heart problems, high blood pressure, chest pain or blue baby? **YES NO**
13. Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea, constipation, colic, food intolerance, bladder problems, or jaundice? **YES NO**
14. Urinary: Pain, increased frequency of urination, infections or blood in urine? **YES NO**
15. Reproductive: Infections, swelling, testicular masses, painful menses, bed wetting, or sexually transmitted diseases? **YES NO**
16. Musculoskeletal: Joint pain, swelling, back pain, neck pain, bone or muscle pain, sports injuries, arthritis, problems walking or scoliosis? **YES NO**
17. Neuological: Fainting, blackouts, seizures, weakness, numbness, tingling, memory problems, abnormal movements or delayed development? **YES NO**
18. Psychological: Depression, poor memory, nervousness or poor thinking? **YES NO**
19. Endocrine: Thyroid problems, excessive sweating or diabetes? **YES NO**
20. Hematologic: Anemia, bruising, bleeding or transfusions? **YES NO**
21. Has your child ever broken a bone? **YES NO**

(773) 697-8088 PHONE • (888) 404-8086 FAX
1654 W NORTH AVE, CHICAGO, IL 60622

FAMILY HEALTH HISTORY:

Check if any apply to the child, parents, grandparents or siblings of the child:

____Cancer ____Diabetes ____Scoliosis ____Stroke
____Heart trouble ____Mental illness ____Nerve disorder ____High Blood Pressure
____AIDS ____Anemia ____Tuberculosis ____Kidney disease

DATE OF LAST:

Spinal examination____________________ Physical examination____________________
Urine test____________________ Operation____________________
Hospitalization____________________ Illness____________________

INFORMED CONSENT TO CHIROPRACTIC CARE:

You understand that the spinal adjustment is used to correct dysfunctions of the spine involving the joints, muscles and nerves that is called a subluxation.

You consent to the performance of a spinal examination in which the doctor uses their hands to feel the muscles and joints of the back and neck (palpation), performs a visual inspection of your posture, checks the ability to move through a normal range of motion for the neck and back, and performs any further orthopedic or neurological tests. X-rays or other imaging may be ordered by the chiropractor.

The tests and spinal adjustments are standard and commonly used. They involve very little risk and serious side effects are rare. Stroke is an extremely rare serious adverse effect associated with cervical (neck) spinal manipulation. The best evidence indicates that cervical manipulation for neck pain is much safer than the use of NSAID's (nonsteroidal anti-inflammatory drugs), by as much as a factor of several hundred times. While no adverse effects are anticipated, the risks are the same as those encountered in a routine visit to any doctor of chiropractic. Some patients may have muscle soreness after chiropractic adjustments or after performing standard physical exam tests.

Spinal adjustments have been used routinely in the management of patients with a variety of symptoms and/or disorders, including those without symptoms who want to improve overall health. Chiropractic is considered part of a wellness lifestyle. I have read and understand this informed consent and I consent to chiropractic examination and care.

X____ ____/____/____
Signature of Parent Date

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