
# More Than Just Adjustments

515 Hamilton Street
Geneva, IL 60134
Phone: 630.232.7611

## Personal Information

Name _____ Today's Date _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Date of Birth _____ Age _____

Social Security # _____ Height _____ Weight _____

Marital Status _____S _____M _____D _____W Spouse _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

Health Insurance Company _____ Member ID _____

Name of Insured _____ Insured's Date of Birth _____

Whom may we thank for referring you to our office? _____

## Current Condition

What brings you to our office today? _____

When did this condition begin? _____ Have you had it before? ____Yes _____No

How often do you have this? _____ Is this condition getting worse? ____Yes _____No

At this moment, how do you rate the pain 1 (least) to 10 (severe)? _____

When the pain is at it's worst, how do you rate the pain 1 (least) to 10 (severe)? _____

Type of pain (circle): Achy Tight Tense Sharp Stiff Stabbing Throbbing Burning Tingling Numb Dull

Nature of pain (circle): Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (1- 25%)

What makes the pain better? _____

What makes the pain worse? _____

Does your pain interfere with (circle): Work Sleep Recreation Activities of Daily Living Everyday Life

Have you seen anyone for this condition? _____ Results _____

Is the condition (circle): Job related Auto Accident Work Accident Slip/Fall Other_____

Date of Accident_____ Has the accident been reported? _____

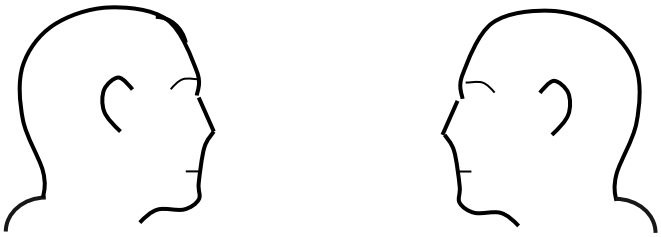
List any other complaints/pain? _____

How do you rate your physical health? _____ Excellent_____Good _____Fair _____Poor

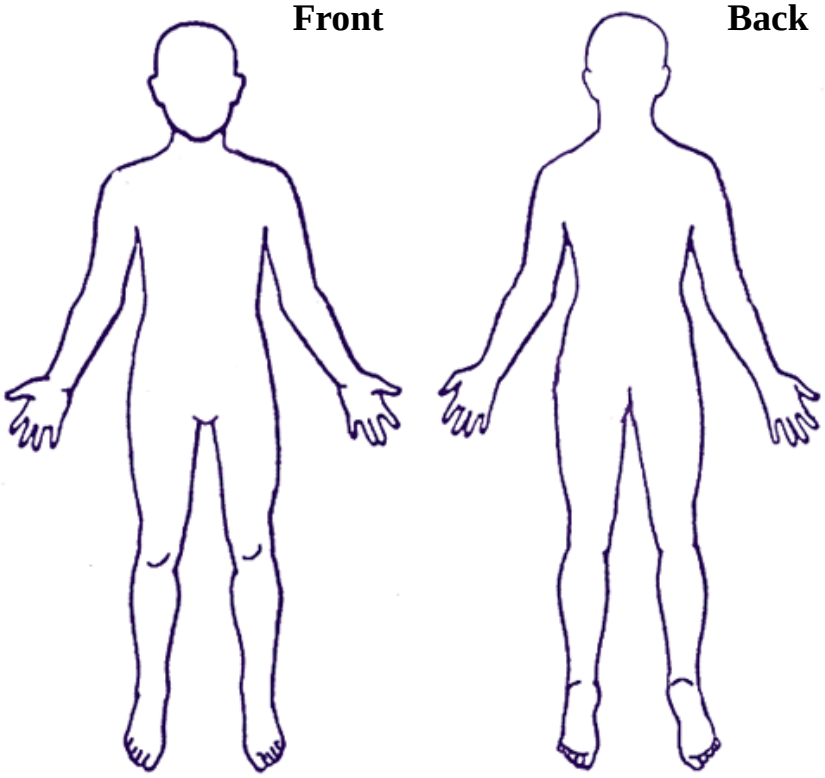
How is this issue affecting your life? _____

**SUBJECTIVE PAIN ASSESSMENT**

**Right** **Left**



**Front** **Back**



**RATE YOUR PAIN**

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
D=Dull
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

## Health Information

Supplements currently taking? _____

Medication currently taking? _____

Do you exercise regularly? If so, how often? _____

Have you ever received Chiropractic care? _____Y _____N Doctor: _____

Approximately how long were you under care? _____ Date of last visit? _____

Why did you stop? _____

How many cigarettes/packs per day? _____ How many alcoholic drinks per day? _____

Do you have any allergies to foods? _____Y _____N

If yes, please list _____

Date of last physical exam/doctor visit: _____ Results of exam: _____

Date of last cholesterol test: _____ Results of exam: _____

## History of Past Injuries

List any surgeries you have had _____

List any accidents/injuries/broken bones_____

Have you ever injured your spine, head, neck ribs, chest back, pelvis or hips? _____Y _____N

If yes, state type of injury and year _____

Have you ever injured, broken, fractured or sprained any bones or joints? _____Y _____N

If yes, state type of injury and year _____

Have you ever been hospitalized? _____Y _____N

If yes, state reason and year _____

## For Women

Are you pregnant? _____Y _____N Date of last menstrual period _____

Date of last Pap Smear/Pelvic Exam: _____ Date of last Mammogram: _____

History of abnormal Pap Smear/Pelvic Exam? _____Y _____N

If x-rays are recommended, your signature is required to indicate you are NOT pregnant.

Signature: _____ Date: _____

If pregnant, due date_____

## For Men (over 35 years old)

What was the date of your last digital rectal exam (prostate exam)? _____ Results: _____

When was your last PSA (Prostate Specific Antigen) blood test? _____ Results: _____

## Confidential Health History

The following items may relate to your current condition. In the space in front of each item, place a P if you PRESENTLY have the problem and an H if you previously HAD the problem. Leave space blank if you NEVER had the problem.

GENERAL
_____ Anemia
_____ Allergies
_____ Bleeding Problem
_____ Cancer/Tumors
_____ Diabetes
_____ Epilepsy
_____ Fainting or Seizures
_____ Fibromyalgia
_____ Gout
_____ Hepatitis
_____ High Cholesterol
_____ Loss of Sleep
_____ Multiple Sclerosis
_____ Night Sweats
_____ Osteoporosis
_____ Tiredness
_____ Thyroid Problems
_____ Weight Loss or Gain

CARDIOVASCULAR
_____ Chest Pain
_____ Heart Disease
_____ High Blood Pressure
_____ Irregular Heartbeat
_____ Low Blood Pressure
_____ Pacemaker
_____ Poor Circulation
_____ Stroke
_____ Swelling of Ankles
_____ Varicose Veins
_____ Heart/Lung Defect

RESPIRATORY
_____ Asthma
_____ Difficult Breathing
_____ Chronic Cough
_____ COPD
_____ Emphysema
_____ Pneumonia
_____ Tuberculosis
_____ Wheezing

MUSCULOSKELETAL
_____ Spinal Curvature
_____ Arthritis

GENITO-URINARY
_____ Bladder Trouble
_____ Difficulty Starting/Stopping Flow
_____ Frequent Urination
_____ Painful Urination

GASTROINTESTINAL
_____ Poor Appetite
_____ Black or Bloody Stools
_____ Bloating/Gas
_____ Colitis/IBS
_____ Constipation
_____ Diarrhea
_____ Excessive Hunger or Thirst
_____ Hemorrhoids
_____ Hernia
_____ Indigestion
_____ Liver Disease
_____ Loss of Bowel Control
_____ Nausea
_____ Reflux
_____ Stomach Pain
_____ Liver Problems
_____ Ulcer
_____ Vomiting

WOMEN ONLY
_____ Abnormal Periods
_____ Dysmenorrhea
_____ Endometriosis
_____ Extreme Cramps
_____ Hot Flashes
Date of Last Period _____
Last Mammogram _____
Last Pap Smear _____

MEN ONLY
_____ Prostate Problems
Last Physical _____

NEUROLOGIC/MENTAL
_____ Anxiety
_____ Anger/Aggression
_____ Attention Deficit
_____ Psychotic episodes
_____ Tremors
_____ Mental Disorder

FAMILY HISTORY
_____ Cancer
_____ Diabetes
_____ Heart Disease
_____ High Blood Pressure
_____ Kidney Disease
_____ Muscle, Bone or Nerve Disease
_____ Thyroid Disease/Goiter
_____ Tuberculosis
_____ Other

## Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on myself (or on the patient named below for which I am legally responsible) which are recommended by the Doctor(s) of Chiropractic at Partner in Health.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the Doctor at Partner in Health and/or with office personnel, the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read (  ) or have had read to me (  ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature of Patient/Guardian: _____ Date: _____

Signature of Insured (If Different): _____ Date: _____

## Privacy Policy (HIPAA)

We are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. If applicable, we may disclose your health information, as deemed necessary by law, to comply with state Workers' Compensation Laws, in cases of medical emergencies, to aid public health agencies such as the CDC and FDA, Governmental agencies as required by law, law enforcement officials and to comply with a court order, preapproved agencies for purposes of organ donation or research, or to proper authorities as recognized by the state in order to assure public safety. Your rights include the ability to request (only) restriction on certain uses and disclosures, to receive protected information by alternate means or at an alternate location, to have your physician amend your protected health information or file a statement of disagreement with your physician, and to receive an accounting of certain disclosures your physicians have made (if any). A more detailed explanation of these rights and responsibilities is readily available upon request, or at www.hfa.gov/medicaid/hippa.

Signature of Patient/Guardian: _____ Date: _____

Signature of Insured (If Different): _____ Date: _____

Thank you for choosing Partner in Heath.

We look forward to improving your health!