Crystal Lake
FAMILY WELLNESS

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

Patient Name

_____

Date Completed

Today's Date:_____

Patient Information

Name:_____Preferred Name:_____

Home Address:_____City, State, Zip: _____

Email Address:_____Cell Phone: (_____)_____

Gender: M / F Birth Date _____/_____/_____ Marital Status: S M D W

Occupation:_____Employer Name: _____

Spouse's Name:_____Spouse's Birth Date:_____/_____/_____

Emergency Contact:_____Phone:_____Relationship:_____

Who can we thank for referring you to our office? _____

Purpose for This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? Y / N If yes, when:_____/_____/_____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe: _____

When did these symptoms begin?_____/_____/_____ Are they: ☐ Constant ☐ Intermittent ☐ Activity-related

Are they getting worse? Y / N Do they interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine

Explain:_____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? Y / N If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? Y / N

If yes, explain: _____

Have you been treated for this? Y / N When were you last treated? _____/_____/_____

Experience with Chiropractic

Have you seen a Chiropractor before? Y / N If yes, who? _____

Reason for visit(s): _____

Health & Lifestyle

Do you use tobacco? Y / N How much?_____

Do you drink alcohol? Y / N How much?/How often? _____

Do you take any medications? (list)_____

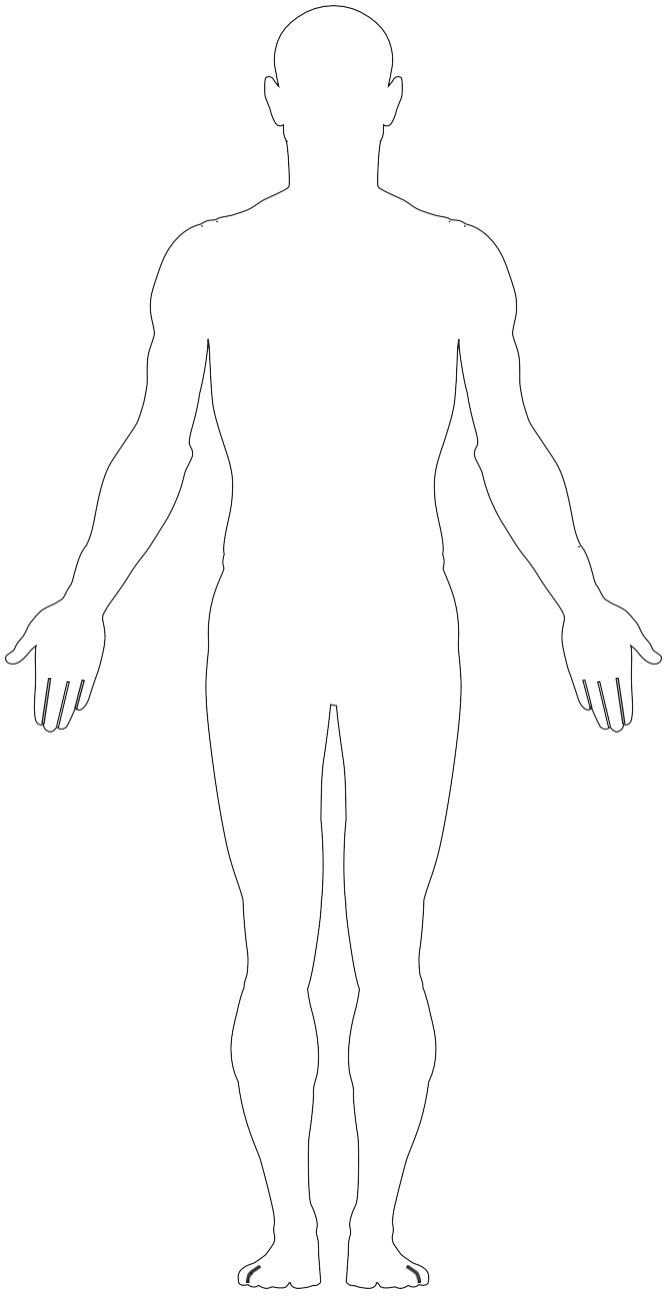
_____

Name_____ Date:_____

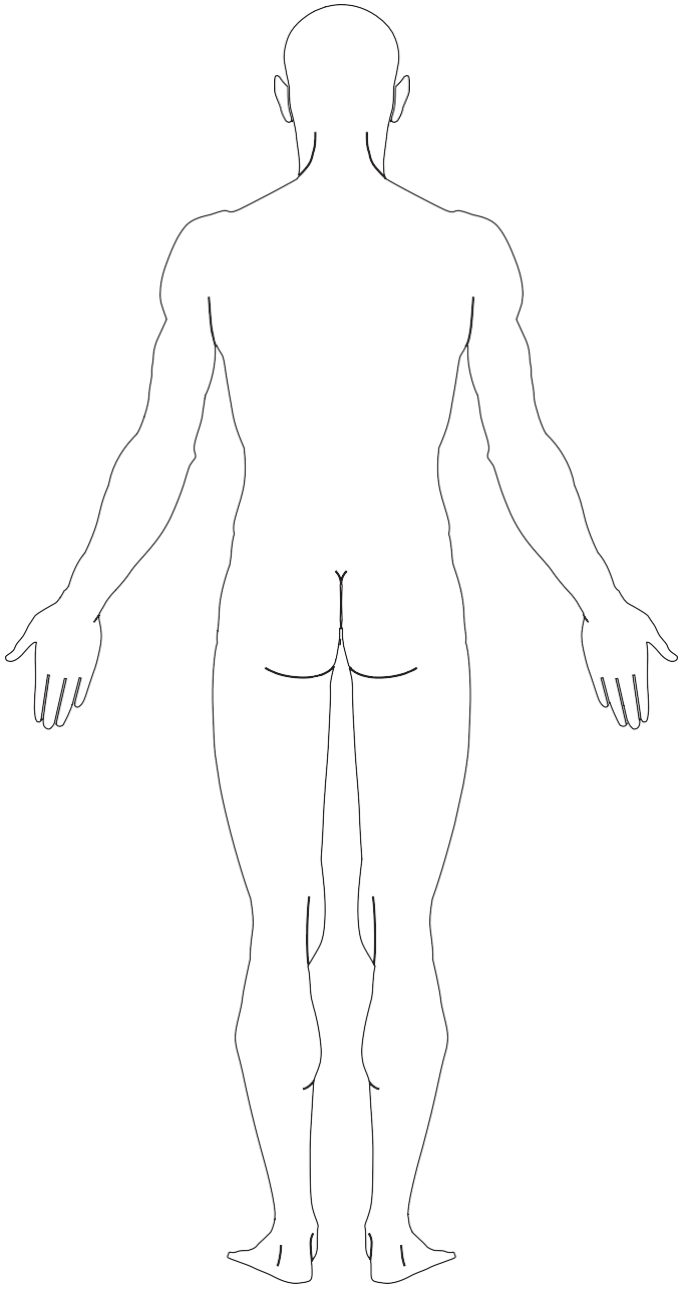
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked “O” for “Other” on any part, please explain below:

_____

_____

Name_____ Date:_____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your condition.

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

CERVICAL SPINE (NECK)

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Headaches
____Dizziness
____Visual disturbances
____Coldness in hands
____Thyroid conditions
____ Sinusitis
____Allergies/Hay fever
____Recurrent colds/Flu
____Low Energy/Fatigue
____TMJ/Pain/Clicking

Please explain: _____

THORACIC SPINE (UPPER BACK)

____ Heart Palpitations
____ Heart Murmurs
____ Tachycardia
____ Heart Attacks/Angina
____Recurrent Lung Infections/Bronchitis
____Asthma/Wheezing
____Shortness of Breath
____Pain on Deep Inhalation/Exhalation of breath

Please explain:_____

THORACIC SPINE (MID BACK)

____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Nausea
____Ulcers/Gastritis
____Reflux
____ Diabetes
____Hypoglycemia/Hyperglycemia

Please explain: _____

LUMBAR SPINE (LOW BACK)

____ Pain in hips/legs/feet
____ Numbness/tingling in legs/feet
____ Frequent/difficulty urinating
____ Constipation/Diarrhea
____ Weakness/injuries in hips/knees/ankles
____Recurrent bladder infections
____Muscle cramps in legs/feet
____Menstrual irregularities/cramping (females)
____ Low back pain
____Coldness in legs/feet
____Sexual dysfunction

Please explain: _____

_____

Please list any health conditions not mentioned: _____

_____

Please list any surgeries (include type of surgery and date it was performed):_____

_____

Crystal Lake Family Wellness Terms of Acceptance

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a person seeks Chiropractic care and we accept a person for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I,_____have read and fully understand the above statements.
(Print name)

All questions regarding the chiropractors objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature:_____Date: _____

Consent to evaluate and adjust a minor child

I,_____being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature:_____Date: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am ***not*** pregnant and the above doctor and staff have my permission to perform necessary X-rays. Date of last menstrual period: _____

Signature:_____Date: _____

HIPAA
Notices of Privacy Practices
Crystal Lake Family Wellness

This notice, effective immediately describes how medical information about you may be used and disclosed and how you can get access to this information, please review carefully. Our office is 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.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for the purpose of payment or health care operations. We have your permission to disclose your health care information to your insurance company for the purpose of appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial and Administrative proceedings, Law Enforcement, Medical examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals, and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Compliance Officer by calling (815) 788-7504.

Complaints – Complaints about your privacy rights or how our office has handled your health information should be directed to our Compliance Officer by calling (815) 788-7504. You may make an appointment for a personal conference in person or by telephone. If you are not satisfied with the manner in which this office handles your complaint, please call (815) 788-7504.

I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____ _____
Patient's Name Date

_____
Patient/Guardian's Signature