

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): _____

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

B = BURNING

P = PINS & NEEDLES

G = STABBING

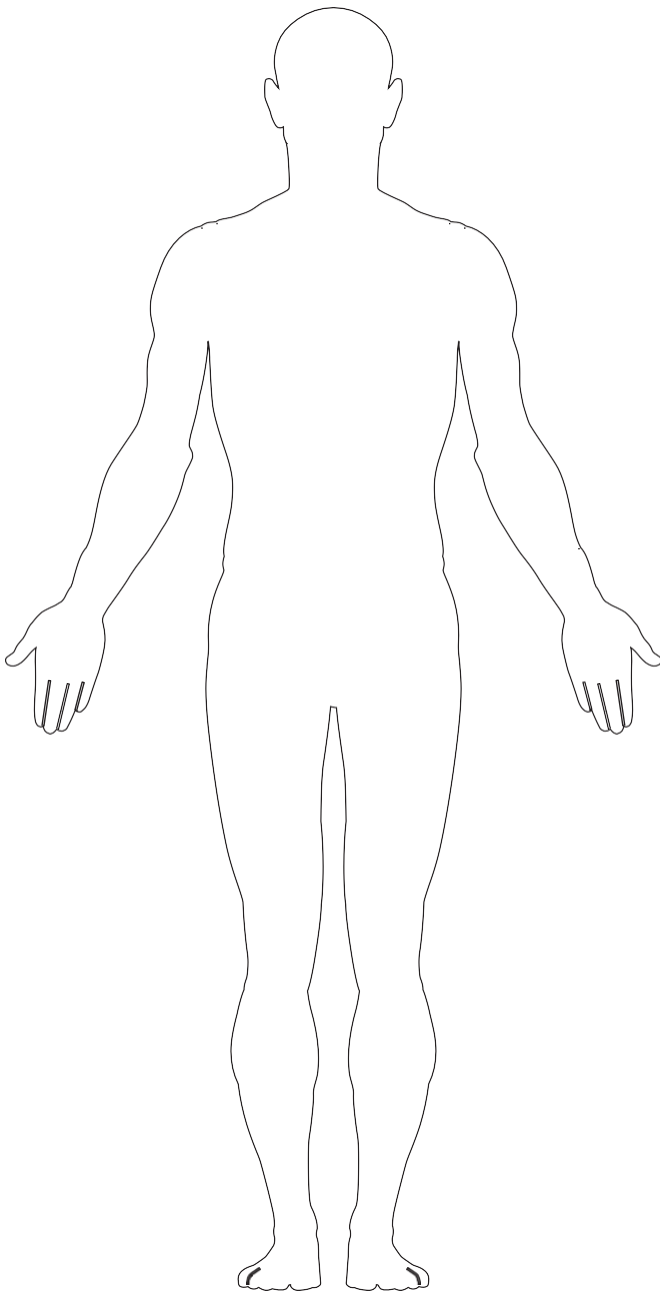
M = SPASMS

F = STIFFNESS

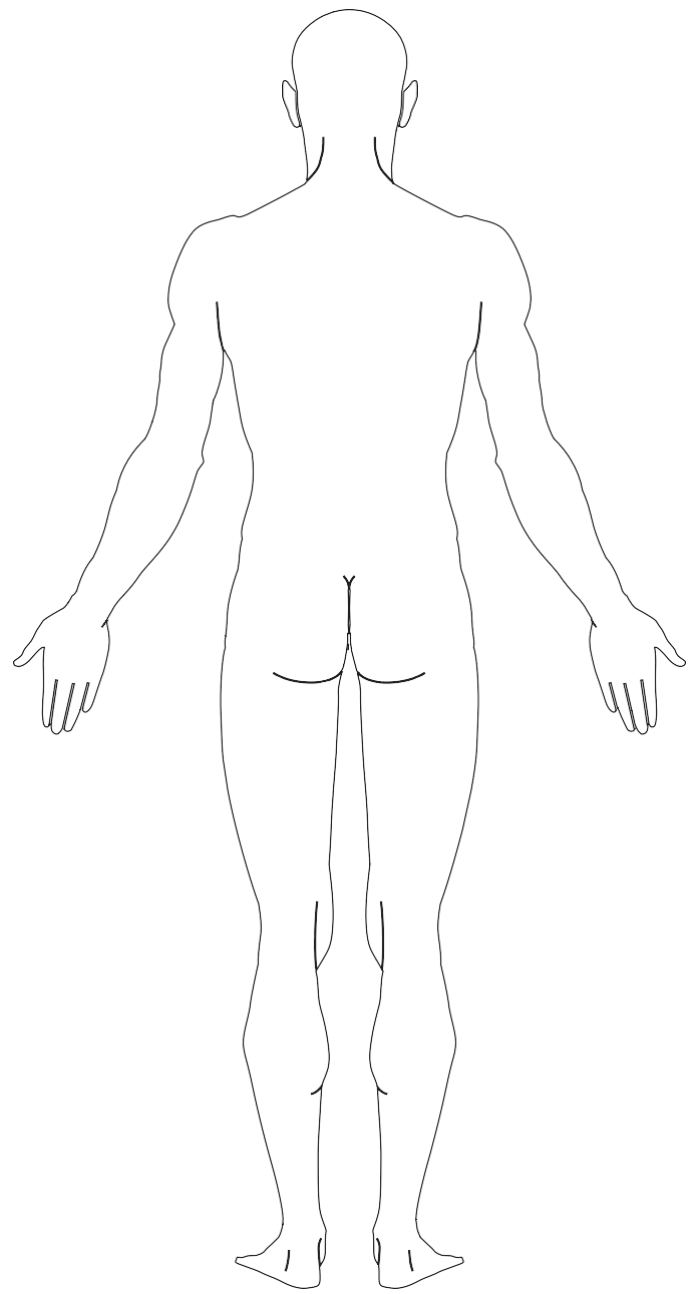
N = NUMBNESS

T = TINGLING

O = OTHER



FRONT



BACK

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

Name _____

Date: _____

Health Conditions

The spine is the gateway between your brain and nervous system. Maintaining it is essential for health and function of the body. The following are some of the common conditions or signs of dysfunction we see when the spine is under stress.

Please indicate all conditions you've experienced.

CERVICAL SPINE (NECK)

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain in shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/Flu |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking |

Please explain: _____

THORACIC SPINE (UPPER BACK)

- | | |
|---|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Pain on Deep Inhalation/Exhalation of breath |

Please explain: _____

THORACIC SPINE (MID BACK)

- | | | |
|--|---|---|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pain in Ribs/Chest | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Hypoglycemia/Hyperglycemia |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Reflux | |

Please explain: _____

LUMBAR SPINE (LOW BACK)

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain in hips/legs/feet | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in legs/feet | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Coldness in legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Muscle cramps in legs/feet | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Menstrual irregularities/cramping (females) | |

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