

# West Chicago Family Chiropractic Case History/Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How many children? \_\_\_\_\_ Names and Ages of Children: \_\_\_\_\_

Name of Nearest Relative: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case:

Major Medical  Medicare  Worker's Compensation  Auto Accident

Medical Savings Account & Flex Plans  Other

Name of Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

GBW820052746

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. [The following person\(s\) have my permission to receive my personal health information:](#)**

\_\_\_\_\_  
Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

## HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: \_\_\_\_\_

Date symptoms appeared or accident happened: \_\_\_\_\_

Is this due to: Auto \_\_\_ Work \_\_\_ Other \_\_\_\_\_

Have you ever had the same or a similar condition? \_\_\_ Yes \_\_\_ No If yes, when and describe: \_\_\_\_\_

Days lost from work: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

Do you have a history of stroke or hypertension? \_\_\_\_\_

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? \_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Do you have any allergies to any medications? \_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

Do you have any allergies of any kind? \_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

Do you have any Congenital Condition? \_\_\_ Yes \_\_\_ No If YES, Describe \_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now

P = Previously

Headaches _____	Frequency _____
Neck Pain _____	
Stiff Neck _____	
Sleeping Problems _____	
Back Pain _____	
Nervousness _____	
Tension _____	
Irritability _____	
Chest Pains/Tightness _____	
Dizziness _____	
Shoulder/Neck/Arm Pain _____	
Numbness in Finger _____	
Numbness in Toes _____	
High Blood Pressure _____	
Difficulty Urinating _____	
Weakness in Extremities _____	
Breathing Problems _____	
Fatigue _____	
Lights Bother Eyes _____	
Ears Ring _____	
Broken Bones/Fractures _____	
Rheumatoid Arthritis _____	
Excessive Bleeding _____	
Osteoarthritis _____	
Pacemaker _____	
Stroke _____	
Ruptures _____	
Eating Disorder _____	
Drug Addiction _____	
Gall Bladder Problems _____	
Ulcers _____	

Loss of Balance _____
Fainting _____
Loss of Smell _____
Loss of Taste _____
Unusual Bowel Patterns _____
Feet Cold _____
Hands Cold _____
Arthritis _____
Muscle Spasms _____
Frequent Colds _____
Fever _____
Sinus Problems _____
Diabetes _____
Indigestion Problems _____
Joint Pain/Swelling _____
Menstrual Difficulties _____
Weight Loss/Gain _____
Depression _____
Loss of Memory _____
Buzzing in Ears _____
Circulation Problems _____
Seizures/Epilepsy _____
Low Blood Pressure _____
Osteoporosis _____
Heart Disease _____
Cancer _____
Coughing Blood _____
Alcoholism _____
HIV Positive _____

**Patient Acknowledgement and Receipt of  
Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health  
Information**

Name \_\_\_\_\_  
Name

Date \_\_\_\_\_

Print Patient's

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By \_\_\_\_\_  
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By \_\_\_\_\_  
Signature of Parent/Guardian (circle one)

# West Chicago Family Chiropractic

Michael L. Bauer, D.C.  
171A N. Neltnor Blvd.  
West Chicago, IL 60185  
(630) 231-0777 Fax (630) 231-0667

Name of Patient \_\_\_\_\_ Date \_\_\_\_\_

## WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

**Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.**

1. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.
2. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.
3. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.
4. Unless indicated by the doctor, you may return to work/school after your appointment.

I have read and understand the instructions given for my follow-up care.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DOCTOR \_\_\_\_\_

DATE OF VISIT \_\_\_/\_\_\_/20\_\_\_ Patient \_\_\_\_\_ Age \_\_\_\_\_

**Check ONE:**    \_\_\_ INITIAL EXAMINATION    \_\_\_ RE-EVALUATION    \_\_\_ NEW CONDITION

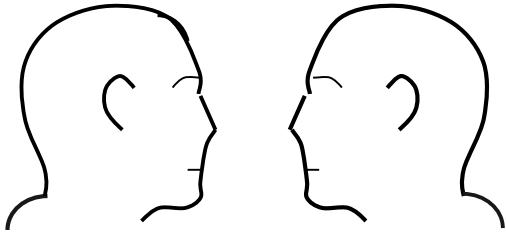
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms \_\_\_\_\_

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? \_\_\_\_\_

**SUBJECTIVE PAIN ASSESSMENT**

**Right**

**Left**

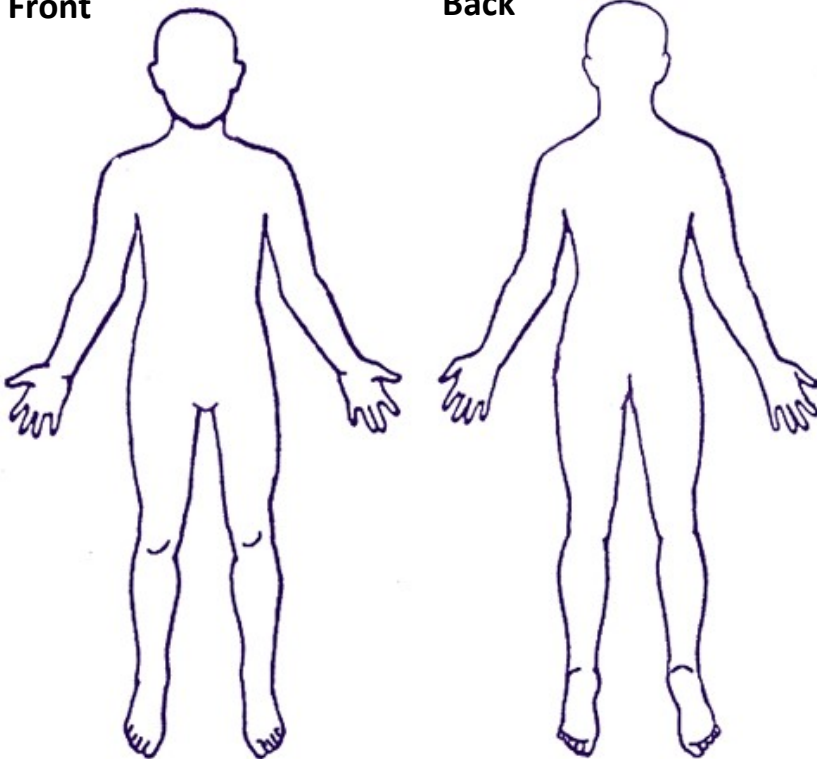


**RATE YOUR PAIN**

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

**Front**

**Back**



- A=Ache
- 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)

**PAIN SCALE:** Please circle the number that best describes your overall pain:

0    1    2    3    4    5    6    7    8    9    10    10+

NONE                      LITTLE                      MEDIUM                      SEVERE                      EXCRUCIATING

**PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE**

**DATE**

\_\_\_\_\_

\_\_\_\_\_