WELCOME TO: Gurnee Chiropractic & Physical Rehabilitation
To insure proper case information, please provide us with the following information.
If you need assistance in completing these forms, please step to the front desk.

Today's date _____

Name _____ Nick-name preferred: _____

Date of Birth _____ ☐ Male ☐ Female Soc.Sec # _____

Mailing Address _____

City, State, Zip _____ Home Phone _____

Occupation _____ Email _____

Employer _____ Work Phone _____

Employer's Address : _____

City, St, Zip _____

Were you referred by ☐ Yourself ☐ Friend ☐ Insurance Carrier ☐ Primary physician ☐ Other physician

Name of person who referred you: _____

If different from above, who is your family physician? _____ Phone # _____

IF WE HAVE COPIES OF YOUR INSURANCE CARDS YOU MAY SKIP THIS SECTION

FINANCIAL :	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
NAME		
ADDRESS		
CITY,ST.ZIP		
POLICY #		
INSURED NAME		
RELATION		
SOC. SEC. #		
BIRTH-DATE		
GROUP #		
EMPLOYER NAME		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

_____ _____
Signature Date

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

Did it come on: ☐ Suddenly ☐ Built up over several days ☐ Gradually worse over a long time.

If you were injured was it: ☐ At Work ☐ At Home ☐ Due to Auto Accident ☐ Other Injury

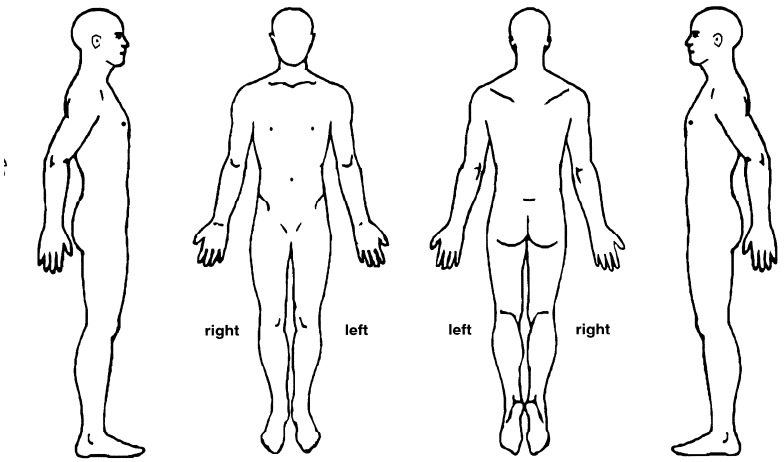
ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

+++	Burning	///	Stabbing
....	Pins & needles	xxx	No feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time and how frequent.

AREA 1 pain is (1-10) ___ Constant or Intermittent

AREA 2 pain is (1-10) ___ Constant or Intermittent



Please help us understand your pain: **Circle the words** for each area that best describes your pain and activity during your day.

Area 1 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 2 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 3 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am : Ambulatory without assistance Need to use: Support Brace _____ Walker Cane Crutches Wheelchair

Please help us better understand **your personal circumstances** and assist us in providing you customized treatment and care.

I Am Now: ☐ Working Full Time Part Time ☐ Homemaker ☐ Full Time Student ☐ Unemployed ☐ Retired

Occupation: _____

☐ On sick leave ☐ On Temp disability ☐ On Full Disability My last day worked was _____

Age _____ Single Married Separated Filing for Divorce Divorced

Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.

I Now ◯ Smoke ___ Packs per day Stopped _____ ◯ Use Alcohol Type and Amt _____

◯ Consume Caffeine: Type/ Amt _____ ◯ Use recreational drugs _____

I am now or have in the past been : ◯ Addicted to drugs alcohol ◯ Treated for alcohol or drug addiction

WOMEN ONLY Can you become pregnant? YES NO Date of last period _____ Normal Yes No

If not, why? _____ Date of last Mammogram _____ Normal Yes No

Are you now or could you be pregnant ? ? YES NO Pap Smear _____ Normal Yes No

Pertinent History/ Please advise us of any special circumstances, previous tests, therapy or conditions.

Are you allergic to any medications? NO YES (If yes, please list all that you are allergic to below)

If you previously had any of the following procedures, please list the date and place they were performed.

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE RECENT PAST.

Severe headaches / Chest pain / Angina / Kidney Stones / Digestive problems / Hypertension / Renal disease Gout / Stroke / Heart murmur / Diabetes / Arthritis / Epilepsy / Arrhythmia / Endocrine disease / HIV / AIDS Fatigue / Congenital heart disease / Urinary, genital problems / Dizziness / Fainting / Anemia / Reumatic fever / Scarlet fever / Prostate problems / Ulcers / Gall Stones / Sexual dysfunction / Venereal disease / Pancreatitis Shortness of breath / Menstrual dysfunction / Mental Illness / Asthma / Liver disease / Alcohol or Drug problems.

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. *(Prescription and over the counter)*

Name of medication and Strength	**# of doses / *day***

HOSPITALIZATION and SURGERY

PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)

FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

	condition	who?		condition	who?
	Heart Disease			Epilepsy	
	Hypertension			Glaucoma	
	Stroke			Bleeding disorders	
	Cancer			Kidney disease	
	Diabetes			Thyroid disease	

Do you require special care or have any concerns that might affect your treatment or recovery? NO YES (If yes please describe)

Thank you for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To verify that the information is correct as given to us by you, please affix your signature in the area (x) provided below.

Patient Signature: X

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of medical procedures and/or chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractor named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractor named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment or my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name _____ Signature of Patient _____
PLEASE PRINT

Date Signed _____ Witness of Patient's Signature _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITIATED

Patient's Name _____ Signature of Patient _____
PLEASE PRINT

Date Signed _____ Witness of Patient's Signature _____

Relationship or Authority of Patient's Representative _____

Translated by _____ Date _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office _____

Address _____

Name of Doctor's Treating this patient:

1. _____ PIN#_____
PLEASE PRINT
2. _____ PIN#_____
PLEASE PRINT
3. _____ PIN#_____
PLEASE PRINT