HOLISTIC HEALTH&NUTRITION

1164 S Roselle Rd • Schaumburg IL 60193 • office: 847-301-0433 • fax: 847-301-7304

Date: _____

Patient Name: (Last Name First)_____

Cell Phone: _____ Home Phone:_____ Work Phone: _____

Birth Date:_____ Age:_____

Address: _____City: _____

State/Zip_____

Email: _____

How did you find out about Holistic Health and Nutrition? _____

Have you ever been to a Chiropractor? Yes No If yes, please describe: _____

_____

In Case of Emergency, who should we contact?

Name: _____ Phone: _____ Relationship: _____

PRIMARY CARE PHYSICIAN:

Name/Group: _____ Phone: _____

Address: _____Date Of Last Physical:_____

Date of Recent/last Lab Work:_____

FAMILY INFORMATION:

Marital Status: Single Married Partner Divorced Widow(er)

Spouses Name: _____ Children: Y N Number: _____

EMPLOYER INFORMATION:

Occupation: _____

Employer: _____ Employer Phone:_____

Employer Address: _____ City: _____ State/Zip:_____

INSURANCE INFORMATION:

Insurance Company Name: _____

Member Services Phone: _____ Group or Plan #: _____

Name of Insured: (if different from patient)_____ Phone: _____

Birth Date:_____ Age:_____

Address: _____ City: _____

State/Zip_____

Insured's Employer: (if different from patient)_____ Phone: _____

Address: _____ City: _____

State/Zip_____

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Health Holistic and Nutrition all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

ACCIDENT INFORMATION:

Is this condition due to an accident: Yes No Date of accident: _____

Type of accident: Auto Work Home Other_____

To whom have you made a report of your accident? _____

WORK ACTIVITY:

Sitting _____ Standing _____ Light Labor _____ Heavy Labor _____

HABITS:

Circle the level of stress you are usually experiencing (1 is the lowest) 1 2 3 4 5 6 7 8 9 10

Smoking _____ packs/day _____ Alcohol _____ drinks/day _____ Coffee/Caffeine _____ cups/day_____

How many hours do you typically sleep per night? _____

What do you do for exercise? _____

Are you Pregnant? Yes No Due Date: _____

INJURIES, SURGERIES, HOSPITALIZATIONS:

Procedure	Reason	Outcome	Date

CURRENT AND PAST ILLNESSES OR DISEASES: (Diabetes, Heart Disease, Cancer etc…)

Illness	Onset of Illness

CURRENT MEDICATIONS:

Name of Drug	Reason for Taking	Date Started	Prescribed By

CURRENT SUPPLEMENTS, VITAMINS & HERBS:

Name	Reason for Taking	Date Started	Prescribed By

Please mark any of the following conditions or symptoms that you have currently or have had in the past:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Cold Hands or Feet	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Fibromyalgia	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell/Taste
O Ringing in Ears	O HIV Infection	O Menstrual Cramps
O Jaw/TMJ Problems	O Hepatitis	O Menopause

CHIEF COMPLAINT:

What is the reason for your visit today?

_____

_____

When did your symptoms appear (approximate date)? _____

Have you had similar symptoms in the past? Yes No If yes, when? _____

Describe how it feels (circle all that apply) Numbness Pins & Needles Aching Burning Stabbing Sharp Dull Throbbing Cramps Stiffness Other_____

Activities that are painful to perform: Sitting Standing Walking Bending Lying Down Other _____

Please circle the best description of your symptoms: (please circle) Constant or On & Off

usually lasting _____ min_____ days _____weeks

Is the condition getting progressively worse? Yes No Unknown

Does it interfere with your: (please circle) Work Sleep Daily Routine Recreation Other _____

What treatment have you already received for your condition?

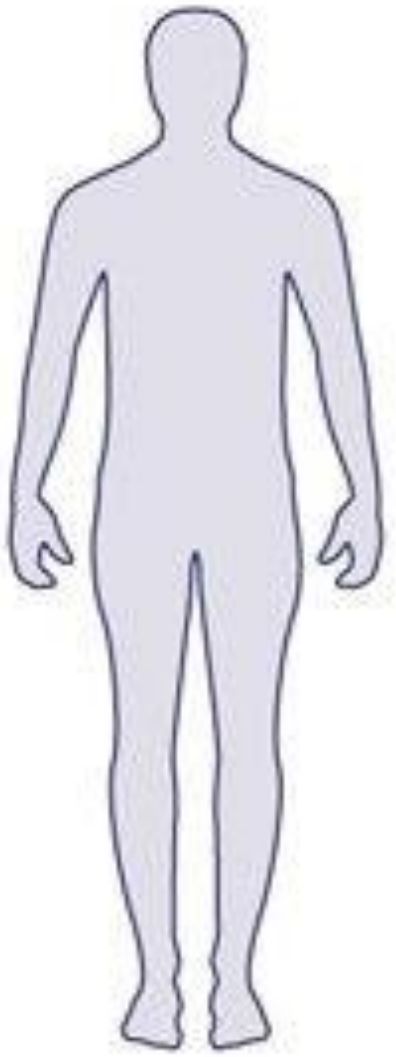
Medications _____ Surgery _____ Physical Therapy ____ Chiropractic Services _____ None ____ Other _____

Please rate your pain on the scales below: 0=No Pain and 10=Severe Pain

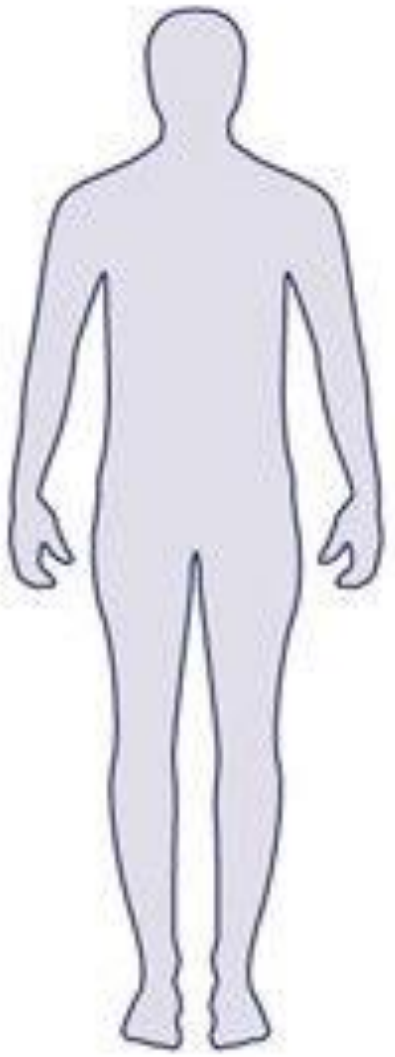
Pain Currently	Pain at its Worst	Pain at its Best
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Please mark area(s) of injury or discomfort on diagram below

NN=Numbness PP=Pins & Needles AA=Aching BB=Burning SS=Stabbing



FRONT



BACK

What makes these symptoms better? _____

What makes these symptoms worse? _____

Additional Information:

_____

_____

_____

_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The Nature of Chiropractic Treatment:
The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise made when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, dry hydrotherapy, or photo light therapy may also be used.

Possible Risks:
As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord.
Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of Risks Occurring:
The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.
OTHER TREATMENT OPTIONS WHICH COULD BE CONSIDERED MAY INCLUDE THE FOLLOWING:

Over the counter analgesics, the risks of these medications include irritation to stomach, liver, and kidneys as well as other side effects in a significant number of cases.

Medical care, typically anti- inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization, In conjunction with medical care adds risks of exposure to virulent communicable disease in a significant number of cases.

Surgery, in conjunction with medical care adds risk to adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated:
Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Unusual Risks: I have had the following risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

I have read and understand the above:
Print name:_____
Signature _____ Date _____

CONSENT TO TREAT A MINOR

I, the undersigned, hereby attest that I am the parent or legal guardian of (child’s name) _____
and give my consent to such examinations and treatments as may be deemed necessary by Dr. _____
for the evaluation and treatment of the condition for which this minor child has been presented.

Signature Parent/Guardian: _____ Date _____

Witness:
Print name:_____
Signature _____ Date _____

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by Contacting Holistic Health and Nutrition, 847-301-0433.

Thank you,
Holistic Health and Nutrition