Palatine Wellness Group

118 W. Northwest Hwy ● Palatine, IL 60067 ● (O) : 847-776-9700 ● (F) : 847-776-9705

PATIENT APPLICATION FOR TREATMENT

Date: _____

Name: _____ Date of birth : _____ / _____ / _____ ❑ Male ❑ Female

Address: _____ City: _____

State: ____ Zip: _____ SS# _____ ❑ M ❑ S ❑ W ❑ D Home: (_____)_____

# of Children _____ What are their ages? _____ Work: (_____)_____

Emergency contact: _____ Phone (_____)_____ Cell: (_____)_____

Employer: _____ Occupation: _____ E-Mail: _____

Do you have health insurance? ❑ Yes ❑ No Job disability in the last 12 months? ❑ Yes ❑ No

Have you ever had Chiropractic Care? ❑ Yes ❑ No If Yes, how long ago? _____

Do you exercise? ❑ Yes ❑ No If Yes, how often? _____ Type? _____

Chief complaint or reason for the office visit? _____

Who referred you to the office? _____

Is your visit a result of an automobile accident? ❑ Yes ❑ No *** If Yes, please ask for our auto accident form. ***

Do you suffer from, been diagnosed as having, or currently have any of the following? **(circle Y or N for each)**

Y N *Broken / Fractured Bones	Y N Congenital Disease	Y N Epilepsy	Y N HIV Positive
Y N Circulatory Problems	Y N High Blood Pressure	Y N Pacemaker	Y N Tumors
Y N *Rheumatoid Arthritis	Y N Low Blood Pressure	Y N Insomnia	Y N *Cancer
Y N Seizures / Convulsions	Y N *Osteoarthritis	Y N Loss of Memory	Y N Strokes
Y N Dizziness/Fainting	Y N Gall Bladder Problems	Y N Cold Hands / Feet	Y N Hand Tremors
Y N Loss of Bladder Control			

* Explanation: _____

NAME OF MEDICATION / VITAMIN	DOSAGE	FREQUENCY	WHO PRESCRIBED	PURPOSE FOR TAKING

Palatine Wellness Group is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Your signature below acknowledges that you have been given an opportunity to read the Notice of Privacy Practices. You are also agreeing to payment and health care operations as described in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____ Account# :_____

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PATIENT HISTORY

Chief Complaint : _____ When did it start? _____

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

Has the pain ever been a level 9 or 10? ❑ Yes ❑ No

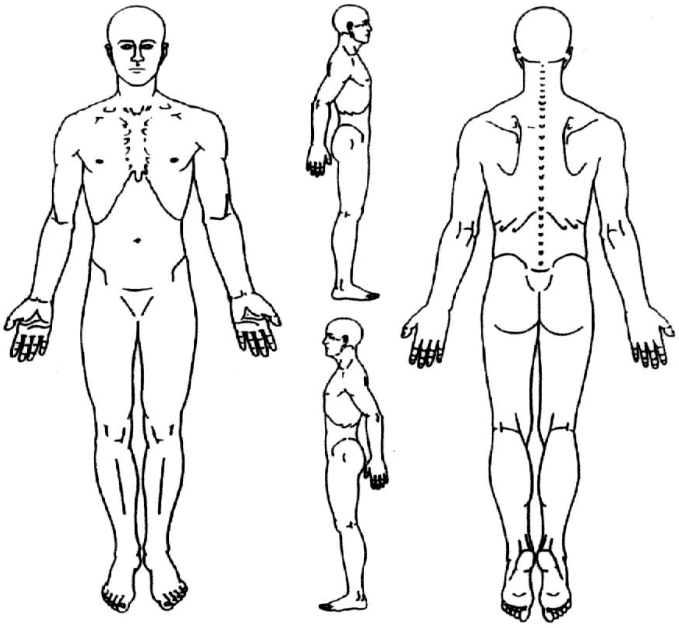
When do you feel it most? ❑ AM ❑ PM When present, how long does the complaint last? _____ Mins _____ Hrs

What makes your pain worse? _____ What makes your pain better? _____

Note: If you need additional sheets, please ask the front desk.

Please show **where** on the body below you are experiencing **all** of your current complaints by placing the letter(s) on the left on that specific area.

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain



Do you currently have pain and/or difficultly performing any of the following activities? (Circle Y or N)

Carrying	Y	N
Driving	Y	N
Pulling objects	Y	N
Picking up objects	Y	N
Personal Care	Y	N
Sleeping	Y	N
Running	Y	N
Walking	Y	N
Standing	Y	N
Pushing	Y	N
Sitting to standing	Y	N

1. Have you ever had the condition(s) in the past? ❑ Yes ❑ No If yes, please indicate what sort of treatment have you ever had: ❑ Hospitalization ❑ Chiropractic care ❑ Medical doctor / Specialty provider ❑ None
2. Have you ever lost work due to your condition(s)? ❑ Yes ❑ No If Yes, dates? _____
3. Are you pregnant? ❑ Yes ❑ No Number of pregnancies? _____ Number of miscarriages? _____
4. What was the first day of your last menstrual cycle? _____

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem(s)?

Low Medium High

0	1	2	3	4	5	6	7	8	9	10

Patient Name (please print): _____ Account # _____

Patient Signature _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

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WELCOME TO OUR OFFICE

I hereby request and consent to the performance (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic who now or in the future work at this office listed above. I will have opportunity to discuss with the doctors of chiropractic practicing in this clinic and/or with other office or clinic personnel the nature and purpose of the procedures indicated above. I understand that results are not guaranteed if I consent to treatment.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I will have an opportunity to ask questions about its content, and by signing below I am agreeing to the treatment recommendations that the doctor will lay out for me with the exception of the procedures I decline to undergo. By declining any of the procedures, I understand that the doctor may be working from limited information and that I understand and take full responsibility for the fact that this may affect the overall outcome of my care and possibly not reveal any potential abnormal findings that would be viewed or exposed with the use of further diagnostic investigation.

I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment for at this office.

Patient Name (please print): _____ Account # _____

By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

Patient Signature: _____ Date: _____

Witness Name (please print): _____

Witness Signature: _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.