

**Patient Health History**

**Today’s Date Signature of Patient**

 / /

**Patient Title:** *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

**First Name** **Nick Name**

**Last Name Middle Name Suffix**

**Address 1**

**Address 2**

**City State Zip Code**

**Primary Phone Secondary Phone**

**Mobile Phone**

**Home email**   **Work Email**

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

**Which email address would you like us to use to communicate with you?** *(check one)*❑ Home ❑ Work

**Contact Method** *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

**Date of Birth Age**  **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

 / /

**Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other **SSN**

**Employment Status** *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

**Race** *(check one)*

 ❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native

 ❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island

 ❑Samoan ❑ Guamanian or Chamorro ❑Other ❑ I choose not to specify

**Multi-Racial** *(check one)* ❑Yes ❑No ❑ Unknown

**Ethnicity** *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

**Preferred Language** *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German

❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish

❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi

❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Continued …

**Verification Question** *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?

❑ What is your favorite movie? ❑ What is your mother’s maiden name? ❑ On what street did you grow up? ❑ What was the make of your first car? ❑ When is your anniversary?

**Verification Answer to the Chosen question:**

 *Answers must be at least* ***6*** *characters.*

**Do you currently smoke tobacco of any kind?** ❑ Yes ❑ Former smoker ❑ Never been a smoker

***If yes, how often do you smoke:*** ❑ Current every day smoker ❑ Current sometimes smoker

***If yes, what is your level of interest in quitting smoking?***

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

 *No interest       Very Interested*

**Current medications, including *frequency and dosage* if known. If there are no current medications,**

**check here: ❑**

Dosage

Dosage

**1) 5)**

**2) 6)**

**3) 7)**

**4) 8)**

**List any known allergies you have had to any medications.**

**If no allergies are known, check here: ❑**

**1) 3)**

**2) 4)**

**Briefly list your main health problems:**

**Has any doctor diagnosed you with Hypertension presently?** ❑ Yes ❑ No If yes, describe:

**Has any doctor diagnosed you with Diabetes presently?** ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

 ***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*** ❑ Yes ❑ No ❑ Not Sure

 ***If yes, other comments regarding Diabetes:***

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?** ❑ Yes ❑ No

**To be performed by clinic staff:**

**Height:** inches **Weight:** pounds **BP:** /

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this a result of an Auto or Work Injury:** Y N **If Yes…**

Name & address of Workman’s Comp Carrier or Auto Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorney Name, address & phone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information contained in this packet is true and accurate to the best of my knowledge. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize the release of any medical or other information necessary to process this claim. Please allow Absolute Wellness Ltd. to also attain information on my medical history in order to better understand my condition. I also request payment of government benefits either to myself or to the third party who accepts assignment. Furthermore, I understand that Absolute Wellness Ltd. will prepare any necessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid directly to Absolute Wellness Ltd. will be credited to my account upon receipt. I clearly understand and agree that **I** **am personally responsible for payment.** I further authorize Absolute Wellness Ltd. to call me at the above listed number for appointment reminders and other office matters. I understand that Absolute Wellness Ltd. is the corporate name and is operating as Lakeside Chiropractic.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Guardian 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

When a patient seeks chiropractic care it is essential for both the patient and doctor to be working towards the same objective. It is important that the patient understand both the objective and method that will be used to attain this goal. This will prevent any confusion or disappointment.

***CHIROPRACTIC MEDICINE***

Chiropractic medicine is made up of many tools and techniques. The most important tool *and* technique is the manual manipulation or the “adjustment”. An adjustment is a specific application of forces to facilitate the body’s correction of a mal-alignment of the joints in the body. Techniques used to aid the adjustment include but are not limited to: soft tissue techniques, stretching, rehabilitation exercises, nutritional advice and life-style advice. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts known, is in my best interests. I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing chiropractic procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

***HEALTH***

Health is the state of *optimal* physical, mental, and social well being, not merely the absence of disease or infirmity. Just because there are no symptoms does not mean that there is no problem. If the problem is caught early enough, it can be corrected with minimal pain or discomfort. If the problem is allowed to persist, irreversible changes may occur causing permanent damage and pain. Prevention is the key.

I have read and fully understand the above statements. All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my complete satisfaction. I request and consent to the performance of chiropractic adjustments, acupuncture and/or other chiropractic procedures on me or the minor in question by any licensed doctor of chiropractic who may be employed by or engaged in practice in Lakeside Chiropractic.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Privacy Practices Acknowledgement:**

I have received the Notice of Privacy Practices and have been given an opportunity to review it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**PAIN LOCATION**





Please number the areas of your complaint on the diagram above and fill in the following chart:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Number** | **Pain Type** | **How long have you had it?** | **What caused it?** | **1-10 pain scale &****Frequency** |
|  | 🞎 Sharp 🞎 Dull 🞎 Throbbing🞎 Numbness 🞎 Aching🞎 Shooting 🞎 Burning🞎 Tingling 🞎 Cramps🞎 Stiffness 🞎 Deep🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Constant OR Come and go |
|  | 🞎 Sharp 🞎 Dull 🞎 Throbbing🞎 Numbness 🞎 Aching🞎 Shooting 🞎 Burning🞎 Tingling 🞎 Cramps🞎 Stiffness 🞎 Deep🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Constant OR Come and go |
|  | 🞎 Sharp 🞎 Dull 🞎 Throbbing🞎 Numbness 🞎 Aching🞎 Shooting 🞎 Burning🞎 Tingling 🞎 Cramps🞎 Stiffness 🞎 Deep🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Constant OR Come and go |
|  | 🞎 Sharp 🞎 Dull 🞎 Throbbing🞎 Numbness 🞎 Aching🞎 Shooting 🞎 Burning🞎 Tingling 🞎 Cramps🞎 Stiffness 🞎 Deep🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Constant OR Come and go |

Health History

Circle P if you’ve had this condition in the past (6 months).

Circle C if it is a current problem (1 month).

Leave Blank if Never.

Hospitalizations

110. List Dates and Reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childhood Diseases

1. P C Measles
2. P C Chicken Pox
3. P C Mumps

Women Only

1. P C Live Births
2. P C Miscarriage
3. P C Painful Periods
4. P C Excessive Flow
5. P C Irregular Cycles
6. P C Vaginal Burning/Itching
7. P C Hot Flashes
8. Date Last Period Began: \_\_\_/\_\_\_/\_\_\_
9. Date of Last PAP Test: \_\_\_/\_\_\_/\_\_\_
10. Date of Last Mammogram: \_\_\_/\_\_\_/\_\_\_

Accidents/Trauma

1. P C Motor Vehicle Accidents
2. P C Other Trauma/Accidents

Men Only

1. P C Testicular Swelling/Pain
2. P C Prostate Problems

Gastrointestinal

1. P C Poor Appetite
2. P C Poor Digestion
3. P C Difficulty Swallowing
4. P C Belching or Gas
5. P C Frequent Nausea
6. P C Vomiting
7. P C Vomiting Blood
8. P C Pain over Abdomen
9. P C Ulcer
10. P C Black or Bloody Stools
11. P C Liver Problems
12. P C Gall Bladder Problems
13. P C Jaundice
14. P C Hernia
15. P C Diarrhea
16. P C Constipation
17. P C Hemorrhoids
18. P C Appendicitis

Neurologic

1. P C Weakness
2. P C Twitching
3. P C Tremors
4. P C Headache
5. P C Fainting
6. P C Dizziness
7. P C Convulsions
8. P C Epilepsy
9. P C Numbness/Tingling
10. P C Arm/Leg Pain
11. P C Mental Disorder

Skin

1. P C Itching
2. P C Bruising Easily
3. P C Change in Mole(s)
4. P C Skin Cancer

Eye, Ear, Nose, Throat

1. P C Poor Vision
2. P C Pain in Eye(s)
3. P C Difficulty Hearing
4. P C Nosebleeds
5. P C Nose Problems
6. P C Sinus Trouble
7. P C Dental Problems
8. P C Hoarseness
9. P C Tonsilectomy

Genitourinary

1. P C Frequent Urination
2. P C Painful Urination
3. P C Blood in Urine
4. P C Kidney Disease
5. P C Urinary Infection
6. P C Inability to Control Urination
7. P C Difficulty Starting Urine Flow
8. P C Get up \_\_times per night to urinate
9. P C Breast Lump or Pain
10. P C Venereal Infection
11. P C Sexual Difficulties

Cardiovascular

1. P C Irregular Heartbeat
2. P C High Blood Pressure
3. P C Pain Over Heart
4. P C Previous Heart Trouble
5. P C Ankle Swelling
6. P C Varicose Veins
7. P C Rheumatic Fever
8. P C Stroke

General

1. P C Fever
2. P C Chills
3. P C Night Sweats
4. P C Loss of Sleep
5. P C Fatigue
6. P C Nervousness
7. P C Weight Loss or Gain
8. P C Allergies
9. P C Bleeding Problems
10. P C Anemia
11. P C Diabetes
12. P C Cancer
13. P C Thyroid Disease/Goiter
14. P C Alcoholism
15. P C Drug Abuse
16. P C HIV Risk Factors

Respiratory

1. P C Difficult Breathing
2. P C Chronic Cough
3. P C Spitting Phlegm
4. P C Spitting Blood
5. P C Wheezing/Asthma
6. P C Pneumonia
7. P C Tuberculosis

Family History (Circle) Mom/ Dad

1. Diabetes M D
2. Kidney Disease M D
3. High Blood Pressure M D
4. Heart Disease M D
5. Cancer,

Type: \_\_\_\_\_\_\_\_\_\_\_\_ M D

Exercise (Circle)

1. None
2. 1-2 times a week
3. 3-5 times a week
4. 6-7 times a week

Habits

1. P C Smoking \_\_\_\_packs/day
2. P C Drinking
3. P C Recreational Drug Use

Nutritional Status

1. P C Tell me about Your Nutrition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. P C Nutritional Supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. P C Herbs/Botanicals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications

1. P C Prescription
2. P C Non-prescription

Surgeries

111. List Dates and Reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Musculoskeletal

1. P C Neck Stiffness/Pain
2. P C Pain Between Shoulders
3. P C Low Back Pain
4. P C Swollen Joints
5. P C Painful Joints
6. P C Muscle Aches/Soreness
7. P C Spinal Curvature (Scoliosis)
8. P C Arthritis

***Lakeside Chiropractic***

**Health Starts Here!**

**7229 State Park Rd Phone: (847) 587-0003**

**Fox Lake, IL 60020 Fax: (847) 587-0210**

 **Foxlakechiropractic.com**

**Office Policies**

**Welcome to our office! Our goal is to serve you with exceptionally friendly and prompt service, and provide the best family health care available. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health**.

**Office Hours**

**Monday\* & Thursday\* 9:00 a.m. – 6:15 p.m.**

**Tuesday Closed**

**Wednesday 9:00 a.m. – 5:00 p.m.**

**Friday 9:00 a.m. – 6:00 p.m.**

**Saturday 9:00 a.m. – 12:00 p.m. (Must have appointment)**

**Dr.’s Tews are occasionally out of the office to attend seminars and conferences to further their education. We will build your schedule around those times.**

**Appointment Scheduling & Missed Appointments**

**Dr.’s Tews have designed a specific course of action to allow proper care, a must for spinal postural correction. If an appointment must be changed, 24 hour notice is appreciated. All missed appointments should be made up later the same day or within 24 hours. Please let us know and changes will be made accordingly.**

**Financial Agreements**

**It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you cannot keep your financial agreement, please inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.**

**Remember**

**Spinal correction and healing take time. If you do not feel satisfied with your body's responses, please make an appointment to discuss this with Dr’s Tews. We want you to get the most from your chiropractic care. Also, feel free to ASK QUESTIONS. In the end you are the one responsible for your health and we want you to feel as comfortable and competent as possible.**

**Referrals**

**The health of your loved ones can greatly depend on your referrals. If you know someone who could benefit from our expertise, please let them know about us so we can help them feel better.**