



PATIENT INFORMATION FORM

Name: _____ Today's Date: ___/___/___

Social Security Number [] [] [] [] [] [] [] [] [] Birth Date: ___/___/___ Age: ___ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian / Foster Parent: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with (check all that apply)? [] Father [] Mother [] Guardian / Foster Parent [] None of These

Marital Status: [] Married [] Separated [] Widowed [] Single How many children? _____

CURRENT ADDRESS OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home)

Street _____ Street _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Phone (____) _____ Phone (____) _____

Email Address: _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ [] FULL-TIME [] PART-TIME

Who should we contact in the event of an emergency? _____ Phone (____) _____

Address of contact person _____

Who may we thank for the referral or how did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? [] YES [] NO Please check ALL that apply.

Did the condition or injury result from automobile accident? [] YES [] NO

Did it result from a work-related accident or cause? [] YES [] NO (briefly describe): _____

Approximately, when did your injury or condition occur? ___/___/___

Primary Care Physician: _____ May we contact your doctor regarding your condition? [] YES [] NO

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Financial Responsibility

Who is financially responsible for your care: [] Health Insurance [] Auto Insurance [] Worker's Compensation [] Self

If this is through your health insurance: List Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/___ Does the policy holder have the insurance through his/her employer? [] YES [] NO If yes, who is the employer? _____

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/___

AUTOMOBILE ACCIDENT INFORMATION

Name: _____

Today's Date: ___/___/___

ACCIDENT DETAILS:

Date of Accident: ___/___/___ Time of Day: _____ AM PM Location of Accident: _____

_____ City or town in which accident took place: _____ State: _____

Were you a Driver Passenger Pedestrian

Were you struck from Behind Right Side Left Side Front

Were you looking straight ahead, to the left, or to the right? Straight Ahead To the Left To the Right

Were you rendered unconscious as a result of the collision? YES NO

Were you taken to the hospital after the accident? YES NO By ambulance or private car? _____

Were you taken to the hospital *immediately* after the accident? YES NO

If not, how much time had elapsed before you went to the hospital? _____

Which hospital were you taken to? _____

Have you been x-rayed since the accident? YES NO If so, where? _____

Have you lost any days of work as a result of the accident? YES NO If yes, how many days have you lost? _____

INFORMATION ABOUT THE PARTIES TO THE ACCIDENT:

Did a police officer write up a police report on the accident? YES NO

If yes, what police department wrote up the report? Hinsdale Other City or Town: _____

Do you have a copy of the police report? YES NO *(if yes, please provide our office with a copy of this report)*

Was a ticket or citation issued by a police officer as a result of the accident? YES NO

Who received the ticket or citation? _____

Do you have any "courtesy slips" or other information concerning the other parties involved in the accident? YES NO

(if yes, please provide our office with a copy of this information)

Did the accident involve a *hit-and-run* driver? YES NO

Are you licensed to drive? YES NO *(please provide our office with a copy of your license)*

Is the car which you normally drive properly registered? YES NO *(please provide our office with a copy of the registration)*

Other: _____

Were you in your own vehicle or someone else's at the time of the accident? Check one.

my own vehicle my spouse's my parent's a friend's other

If you were in someone else's vehicle, answer the following:

Name of Owner: _____

Address of Owner: _____

Was there any property damage to either of the vehicles as a result of the accident?

both vehicles the other person's vehicle the vehicle I was in Neither vehicle was damaged

Your Auto Insurance Company (at the time of accident): _____ Phone or City: _____

Agent: _____ Phone or City: _____

Have you been contacted by an adjuster from the other party's insurance company regarding this claim? YES NO

Name of Adjuster: _____ Company: _____

Phone: _____

Check all that apply: I have settled my personal injury claim with this company I have settled the property damage claim I have signed an agreement which will pay my medical expenses for a period of time (explain) _____

I have not signed any agreement, nor settled any portion of my claim.

Are you currently represented by an attorney? YES NO If NO, do you wish to retain an attorney YES NO

Name of Attorney: _____ Phone or City: _____



Adult Health History Form

Your answers on this form will help us better understand your concerns and conditions better. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age _____ How would you rate your general health? Excellent Good Fair Poor

In order of importance, please list the problems you are interested in having corrected. _____ How long has this been an issue? _____

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____

Is there a time when these problems feel better or worse? _____

Please describe any sudden movements, falls, accidents, etc that have caused your problem(s)? _____

Have you had similar problems in the past? Yes No _____

Names of other providers or any other therapies: _____

Have your health problems Improved Stayed the same Have Become Worse
What makes them better? _____ Worse? _____

Please indicate how this problem interferes with your personal/work life:

Work Activities Effected: _____

Have you missed any days of work? Yes No If yes, dates missed: _____

Home Activities Effected: _____

Recreational Activities Effected: _____

PREVIOUS MEDICAL HISTORY

During the past year, has a Doctor treated your for a health problem? Yes No

If YES, please explain: _____

Have you ever received chiropractic care? Yes No If YES, please list the Doctor, for what problems and outcome: _____

MEDICATIONS: Prescription and non-prescription medications, vitamins, home remedies, birth control pills, herbs, etc. _____

Allergies or reactions to medications: _____

MAJOR MEDICAL EVENT HISTORY: Please list all procedures, complications (if any), and dates:

| Year | Surgery, Illness, Injury | Outcome |
|-------|--------------------------|---------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

***Circle any of the following topics that interest you or you would like more information on:**

- Acupuncture
- Functional Nutrition
- Improving your Golf Game
- Massage Therapy
- Custom Orthotics
- Physical Rehabilitation
- Improving Your Health

REVIEW OF SYSTEMS: Please check any current symptoms you have.

| | | |
|--|---|--|
| Constitutional ___ Recent fevers/sweats ___ Unexplained weight loss/gain ___ Unexplained fatigue/weakness Eyes ___ Change in vision Ears/Nose/Throat/Mouth ___ Difficulty hearing/ringing in ears ___ Hay fever/allergies/congestion ___ Trouble swallowing Cardiovascular ___ Chest pains/discomfort ___ Palpitations ___ Short of breath with exertion Allergies ___ Hay fever ___ Food Allergies List: _____ | Respiratory ___ Cough/wheeze ___ Coughing up blood Gastrointestinal ___ Heartburn/reflux ___ Blood or change in bowel movement ___ Nausea/vomiting/diarrhea ___ Pain in abdomen Genitourinary ___ Painful/bloody urination ___ Leaking urine ___ Nighttime urination ___ Discharge: penis or vagina ___ Unusual vaginal bleeding ___ Concern with sexual functions Endo ___ Cold/heat intolerance ___ Increase thirst/appetite | Skin ___ Rash ___ New or change in mole Neurological ___ Headaches ___ Memory loss ___ Fainting ___ Numbness/Tingling ___ Dizziness Musculoskeletal ___ Joint Pains, Swelling or Stiffness ___ Redness, heat or muscle pain Blood/Lymphatic ___ Unexplained lumps ___ Easy bruising/bleeding |
|--|---|--|

FAMILY HISTORY: Please indicate the current status of your immediate family members (parent, sibling, grandparent, aunt, or uncle) with any of the following conditions:

| | |
|----------------------|----------------------------|
| Genetic disorders | High cholesterol |
| Cancer, specify type | High blood pressure |
| Heart disease | Stroke |
| Depression/suicide | Bleeding/clotting disorder |

SOCIAL HISTORY:

In the past month, have you had little pleasure in doing things, or felt, depressed, anxious or hopeless? Yes No

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Do you smoke? Yes No If yes, how many packs/day? _____

Do you drink? Yes No If yes, how many drinks/day? _____

Do you exercise regularly? Yes No If yes, what type and how often?

Do you consider yourself to have a good social support system (family/friends)? Yes No

Describe a typical diet (only include meals snacks you regularly eat):

Breakfast: _____ Snack: _____

Lunch: _____ Snack: _____

Dinner: _____ Snack: _____

Is there anything else concerning your health that you think is important that was not asked elsewhere on this form? _____

Do you have any other health goals you would like to accomplish? _____

(feel free to continue on the back of this sheet)

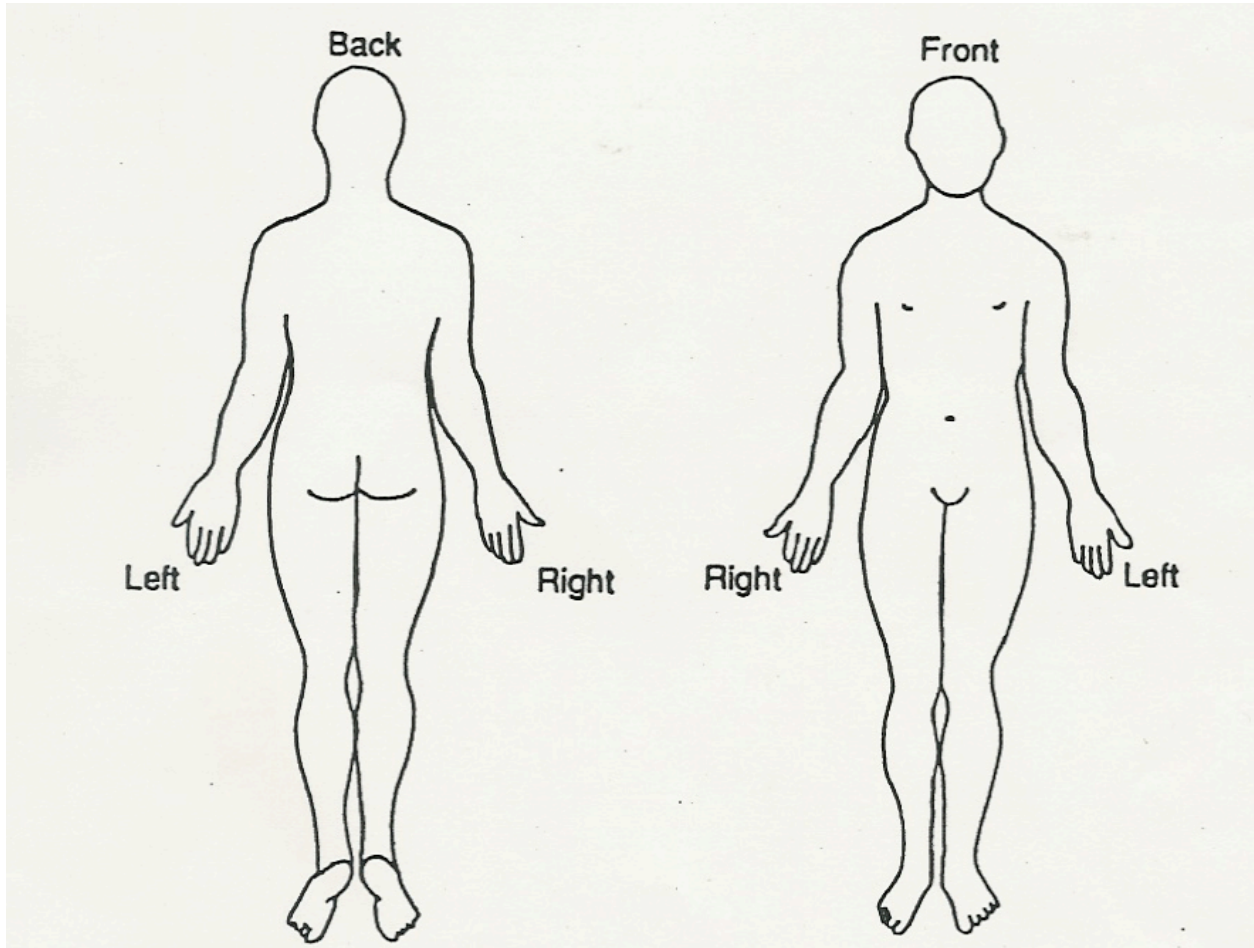
PAIN DIAGRAM

Name: _____ Date: _____

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

Ache-A
Burning-B
Numbness-N

Pins and Needles-P
Stabbing-S
Other-O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling **at this time**.

Date: _____

