Patient Information **Date ___/___/___**

Patient Name (last, first) _____ **Sex: Male / Female**

Home Phone # (_____)_____ **Cell Phone # (_____)**_____

E-Mail Address _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Date of Birth ____/____/____ **Age** _____

Occupation _____

Who Referred You To Our Clinic?_____

Reason forAppointment:_____

_____

When did this begin? _____ **Has it happened before? When?** _____

How did this occur? _____ ___

Since it began, has it: Improved Worsened Unchanged

What have you done for this condition? _____

Who have you seen for this condition? _____

Can you perform your daily home activities?		Yes	Yes, only with help	Not at all
Can you perform your daily work activities?		All activities	Only some	Not at all
Describe your stress level:	None	Mild	Moderate	High
Do you exercise?		Daily	Occasionally	Not at all

Please list any previous surgeries, hospitalizations, injuries (motor vehicle accidents):_____

_____

Have you had any fractures or dislocations? _____

Have you had previous chiropractic care? Yes No Doctor:_____ Date:_____

What do you hope to achieve from this visit? Circle all that apply.

Pain relief Nutritional consultation Performance enhancement

Does your pain increase at night? Yes No

Have you had any unexplained weight loss? Yes No

Name: _____

Date: _____

Previous Medical History

Has a family member ever been diagnosed with the following:

	Arthritis or Osteoporosis	Cancer (where?)	Diabetes	Heart Disease or Stroke	Kidney Disease	Neurologic Disease	Thyroid Disease
Father							
Mother							
Sibling(s)							
Grandparents							

Have you ever experienced the following conditions? Date From_____To_____

Whiplash injury (cervical sprain)?	Yes	No
Were you ever a smoker?	Yes	No
Visual disturbances? (blur, loss, double)	Yes	No
Hearing disturbances? (loss, ringing)	Yes	No
Slurred speech or other speech problems?	Yes	No
Difficulty swallowing?	Yes	No
Dizziness?	Yes	No
Loss of consciousness /blackouts?	Yes	No
Numbness, loss of sensation, strength/weakness?	Yes	No
Sudden collapse without loss of consciousness?	Yes	No

Name: _____

Date: _____

Review of Systems:

Please write in a number: 1. PRESENTLY HAVE 2. PREVIOUSLY HAD 3. RELATED TO CONDITION

General
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss/gain
___Nervousness/depression
___Neuralgia (nerve pain)
___Numbness
___Sweats
___Tremors
___Anxiety/Depression

Eyes, Ears, Nose, Throat
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/ringing
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Near sighted
___Gum trouble
___Hoarseness
___Nasal obstruction

Musculoskeletal
___Arthritis
___Bursitis
___Hernia
___Low back pain
___Mid back pain
___Neck pain/stiffness
___Numbness/pain down the arms or butt/legs
___Arm pain
___Shoulder pain
___Leg pain
___Knee pain
___Foot pain
___Sciatica
___Spinal curvature
___Fractures

Genito-urinary
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection/stones
___Painful urination
___Prostate issues
___Pus in urine

Women Only
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breast
___Vaginal/nipple discharge
___Birth control pills
___Pregnancy complications

Cardiovascular
___High blood pressure
___Low blood pressure
___Heart disease
___Pain over heart
___Rapid heart rate
___Slow heart rate
___Poor circulation
___Swelling of ankles

Respiratory
___Chest pain
___Chronic cough
___Difficulty breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

Gastrointestinal
___Belching or gas
___Abdominal pain
___Constipation
___Diarrhea
___Difficult digestion
___Poor appetite
___Ulcers
___Vomiting
___Vomiting blood
___Abdominal bloating
___Excessive hunger
___Heartburn/reflux
___Hemorrhoids
___Jaundice/liver issues
___Nausea
___Gallbladder issues
___Colitis
___Irritable bowel

Name: _____

Date: _____

Current Medication:

Please list the name and dosage, if possible.

(Include all vitamins/supplements and over-the-counter medications.)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Allergies (medication, food, other substances): _____

_____

WRITTEN CONSENT TO NOTIFY FAMILY PHYSICIAN OF CHIROPRACTIC CARE

At Fox Valley Health, we strive to maintain open communication and professional relationships with other health care providers. In order to provide updates to your family doctor regarding your care, we need to obtain written consent from you as our patient

Family Physician's Name: _____ **Phone:** (_____)_____-_____

Patient Signature: _____ **Patient Name**: _____

Date: ___/___/___ (Please Print)

Name: _____

Date: _____

Insurance Verification (please bring insurance card to your appointment so it can be scanned)

Insurance Company: _____ Insurance ID: _____ Group #: _____

Patient's DOB: _____ Card Holder's Name: _____ Relationship: _____

Deductible Per Year: __$_____ Amount Met: __$_____ Co-payment: _$_____

Co-insurance: _____%_____

Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully. If you have any questions, do not hesitate to ask.

Appointments

1. We value the time we have set aside to see and treat you. If you are not able to keep an appointment, we would appreciate 24-hour notice prior to your scheduled appointment. A late fee of $20 may be charged at doctor's discretion.
2. If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

Financial Responsibility

1. According to your treatment/membership plan, you are responsible for all balances accrued. Your co-payment, co-insurance and unmet deductible may be collected at the time of service.
2. Patient has three months to make a payment on accrued/accruing balance. If no payment has been made on balance after 3 months, physician has the right to file patient with a collection agency. Patient is responsible for all costs and expenses of collection including, but not limited to our reasonable attorneys' fees.
3. We accept cash, checks, Visa, MasterCard, and Discover credit and debit cards.
4. A $20 fee will be charged for any checks returned for insufficient funds.

Assignment of Benefits

I hereby instruct and direct myself, to pay by credit card, cash, or check made out to Fox Valley Health for the professional or medical services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance of said professional service charges.

1. A photocopy of this assignment shall be considered as effective and valid as the original;
2. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case;
3. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I have read and understand Fox Valley Health's financial policy, cancellation/ late policy, as well as the assignment of benefits. I agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name: _____

Patient Signature: _____ Today's Date:_____