

# Chief Complaint History

Referred By: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(Last) (First) (MI)  
 Status: M S W D Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Children? Y N If yes, how many and how old? \_\_\_\_\_

What is your chief complaint?: \_\_\_\_\_ Have you had similar problems? Y N

How long have you had this condition? \_\_\_\_\_ How did it start? \_\_\_\_\_  
 How much does it hurt?:  Mild (Annoyance/No Impairment)  Moderate (Marked Impairment)  Severe (Incapacitated)

Quality/Character:  Dull Ache  Burning  Sharp/Stabbing  Throbbing  
 Tingling  Pins and Needles  Other: \_\_\_\_\_

Duration: (How long does it last?)  Intermittent 0-25%  Occasionally 26-50%  
 Frequently 51-75%  Constantly (100%)

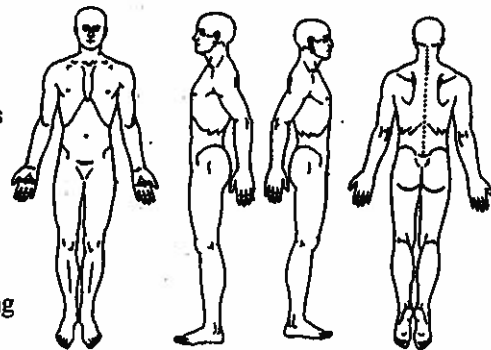
Do you experience any of the following?:  Bowel/Bladder problems  Weakness  
 Referring/Radiating  Other: \_\_\_\_\_

Relieving Factors:  Rest  Exercise  Sitting  Standing  Lying  Heat  
 Ice  Medication \_\_\_\_\_

Other \_\_\_\_\_

Aggravating Factors:  Coughing  Sneezing  Bowel Movement  Lifting  
 Bending  Pushing  Pulling  Walking  Running  Sitting  Standing  Lying  
 Changing Body Positions  Stairs  Other \_\_\_\_\_

Additional information regarding your major complaint: \_\_\_\_\_  
 \_\_\_\_\_ or  Patient Denies comment



P=Pain  
 N=Numb  
 T=Tingling  
 B=Burning  
 C=Crampin

Indicate the areas of your complaint on the diagram to the left.

FOR THIS CONDITION: Have you seen other doctors for this condition? Y N When? \_\_\_\_\_

If yes, who? MD DC DO DDS Other: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Were x-rays taken? Y N Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

Length of time under care: \_\_\_\_\_ Were you off work? Y N Is it progressively worse? Y N

Is this condition due to an accident: Y N Or Illness: Y N

Have you had any surgeries: Y N If yes, list: \_\_\_\_\_

Are you taking any medication: Y N If yes, list: \_\_\_\_\_

What do you think is causing the problem? \_\_\_\_\_

ACCIDENT INFORMATION: (If due to accident please request additional paperwork to describe accident)

Did your accident occur while at work: Y N Were you in an auto accident: Y N

What activities are affected by this condition?: (Circle all that apply)

WORK TIME WITH SPOUSE/CHILDREN HOBBIES EXERCISE  
 SLEEP DRIVING Other: \_\_\_\_\_

How often does this problem affect your life? How bad is the pain? (0=no pain; 10= worst imaginable)  
 \_\_\_ ALL OF THE TIME (75%-100%) V.A.S. \_\_\_/10  
 \_\_\_ MOST OF THE TIME (50-75%)  
 \_\_\_ SOME OF THE TIME (25-50%)  
 \_\_\_ RARELY (0-25%)

How important is it that we help you to you to resolve and correct the(se) health concern(s)?  
 \_\_\_ VITAL \_\_\_ VERY IMPORTANT \_\_\_ SOMEWHAT IMPORTANT \_\_\_ DON'T CARE  
 Once the doctor find the cause(s) of the(se) problem(s), how committed are you to resolving the(se) problem(s)?  
 \_\_\_ VERY COMMITTED \_\_\_ SOMEWHAT COMMITTED \_\_\_ NOT COMMITTED

Any other goals that you hope to reach upon resolution of this problem? \_\_\_\_\_

**IMPORTANT: Please mark (X) all present symptoms**

**HEAD:**

- Headache
- Sinus (allergy)
- Entire head
- Back of head
- Forehead
- Temples
- Migraine
- Head feel heavy
- Loss of memory
- Light-headed
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of balance
- Loss of taste
- Loss of hearing
- Dizziness
- Pain in ears
- Ringing or noises in ears

**NECK:**

- Pain in neck
- Neck pain with movement
  - Forward
  - Backward
  - Turning (L) (R)
  - Bending (L) (R)
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

**SHOULDERS:**

- Pain in joint (L) (R)
- Pain across shoulders
- Bursitis (L) (R)
- Arthritis (L) (R)
- Can't raise arm
  - Above shoulder level
  - Over head
- Tension in shoulders
- Pinched nerve in shoulder (L) (R)
- Muscle spasms in shoulder

**ARMS AND HANDS:**

- Pain in arm
- Tennis elbow
- Pain in hands/fingers (L) (R)
- Pins and needles sensation(L) (R)

- Numbness (L) (R)
- Hands cold
- Loss of grip strength
- Sore/swollen joints in fingers
- Arthritis in fingers

**MIDBACK:**

- Mid-back pain
- Location
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Muscle spasms
- Pain in Kidney area

**CHEST:**

- Chest pain
- Shortness of breath
- Rib pain
- Breast pain
- Dimpled orange peel breast
- Irregular heartbeat

**LOW BACK:**

- Lower back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroiliac
- Low back pain is worse when
  - Working
  - Lifting
  - Stooping
  - Standing
  - Sitting
  - Bending
  - Coughing
  - Lying down
  - Walking

- Pain relieved when \_\_\_\_\_
- Slipped disc
- Low back feels out of place
- Muscle spasms
- Arthritis

**ABDOMEN:**

- Nervous stomach
- Foods can't eat \_\_\_\_\_
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

**MEN ONLY:**

- Urinary frequency
- Difficulty starting

- Night urination
- Prostate swelling

**GENERAL:**

- Nervousness
- Irritable
- Depressed /Run-down
- Fatigue
- Coffee \_\_\_\_\_ cups/day
- Tea \_\_\_\_\_ cups/day
- Cigarettes \_\_\_\_\_ pack/day
- Alcohol \_\_\_\_\_ drinks/week
- Recreational Drug Use
- Diabetes
- Hypoglycemia
- Normal sleep \_\_\_\_\_ Hrs
- Loss of sleep
- Loss of weight \_\_\_\_\_ Lbs
- Weigh gain \_\_\_\_\_ Lbs

**HIPS, LEGS, & FEET**

- Pain in buttocks (L) (R)
- Pain in hip joint (L) (R)
- Pain down leg (L) (R)
- Knee pain (L) (R)
  - Outside
  - Inside
- Leg cramps
- Feet cramps
- Pins and needles in legs
- Numbness in legs/feet
- Swelling in legs/feet

**WOMEN ONLY:**

- Menstrual pain
- Cramping
- Irregularity
- Cycle \_\_\_\_\_ Days
- Birth control \_\_\_\_\_ type
- Hysterectomy
- Tumors/Cancer \_\_\_\_\_
- Discharge
- Menopause \_\_\_\_\_
- Abortions
- Pregnant \_\_\_\_\_ weeks

**Other information you want the doctor to know about you or your condition:**

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

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Terms of Acceptance

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

**Adjustment:** A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print name)

All questions regarding the chiropractors objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

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.  
If you agree sign below.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Pregnancy Release

This is to certify that to the best of my knowledge, I am NOT pregnant and the above doctor and his staff have my permission to perform any necessary x-rays. Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT PRIVACY, OFFICE, AND FINANCIAL POLICIES

The purpose of this is for you to allow us to serve you and our other patients with the highest level of care possible. Our goal as a health care office is to help you achieve your highest potential in the shortest amount of time. It has been our experience that patients that adhere to the following policies will achieve better results. These policies are subject to change without notice and will be available for you at your request.

**Office Hours:** (Subject to change) *Monday, Friday 8-11AM ;3-6PM Tuesday 3-6PM Wednesday 8-11AM and 3-7PM Saturdays 8:30-9:15AM (appointments mandatory—walk-ins may be seen at doctors' discretion).*

Make your next appointment upon leaving the office. If you do not have a future appointment, there can be no guarantee that your doctor will be in the office (i.e., holidays, emergencies, etc.). You may reschedule this appointment to better accommodate your schedule. The last appointment is taken **30 minutes** prior to closing.

**Mobile Phones:** Turn off your mobile phone during your entire office visit. Silence the call immediately if you should forget to silence your mobile phone. In the event of an emergency, please excuse yourself and take the call outside.

**Waiting:** While the doctors are with other patients, please do not disturb them. Although we maintain an open treatment area, the doctors need to be focused on the patient they are with and not being disturbed. If there is a question you would like to ask, please see the front desk for assistance and they will be happy to assist you any way they can.

**Payment of Bills:** Financial responsibility for care rests on the patient or patient's guarantor. Commercial insurance companies, Medicare, Medicaid, or responsible third-party payors will be billed for you at no additional charge. (Auto accidents will be billed to the patient's MedPay first and MedPay must be activated prior to service.) Your out-of-pocket obligation (including, but not limited to, copayments, coinsurance, and deductibles) and payment options/plans will be explained to you after your report of findings from the doctor—you will be expected to make a financial decision at that time. For your initial visit to our office, you will be quoted an exact fee, which is payable prior to service. Any returned checks are subject to a \$25.00 fee. Any insufficient funds/cancelled credit card payments must be remedied immediately and may be subject to penalty. Durable Medical Equipment (DME), supplements, and/or supplies purchased in our office are non-refundable. If your Health Savings Account or Flex Spending Account requires a letter from our office, we will be happy to provide that for you—the staff requires at least five (5) business days' notice to fulfill this request; otherwise it will be subject to a \$50.00 rush fee payable at the time of request.

**Missing/Re-scheduling/Cancelling Appointments:** Per standard of care, your doctor will set you up on a treatment plan with re-evaluations throughout. These appointments are set up to help you reach the results in which we both desire. Keeping your treatment schedule is mandatory. If you must cancel or reschedule an appointment, we require at least 12 hours notice. Any missed appointments without 12 hours notice will count against the number of office visits on your treatment plan. If you schedule for the last appointment of the shift and miss without notification, you will not be allowed to schedule for that time slot in the future. When leaving a message to reschedule, leave your name and phone number, date, and time you would like to reschedule your appointment. The office staff will contact you if there are any conflicts.

**Consent/Receipt Statement/HIPPA:** You give permission to our office to use your information to contact you regarding appointment notifications or treatment alternative, office closures/updates, and when billing insurance for you. You give permission to the office to be treated in an open area where other patients are also being treated. You are aware that other persons in the office may overhear some of your protected health information during the course of care. Should you need to talk to the doctor in private at any time, please inform the staff and that request will be accommodated.

**Inclimate Weather:** In the event of inclimate weather/office closure, call the office immediately as we will have an update on our voicemail. The doctors will do everything they can to ensure that patients are seen, but your safety remains our first concern. Please listen to the entire message as there may be different office hours to help accommodate safe road travel.

"I have read, understand, and accept these policies and understand that they may change at any time. I have a right to view new office policies and the staff will provide them to me upon my request."

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Patient or Patient's Guarantor (Signature)

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Date

Radiological Freedom of Information Agreement

I, \_\_\_\_\_, understand that x-rays may be necessary for my diagnostic workup and treatment plan. I have a right to check them out of the office should I desire to do so. *I understand that any x-rays taken at this location are the property of the doctor's office.*

If I choose to checkout my x-ray films, I may check the films out for fourteen (14) days. Films will not be sent through the mail; they must be picked up in person by the patient or legal guardian, according to HIPPA statutes. If I fail to return the x-ray films back to the office at 1445 Palatine Road, Hoffman Estates, IL 60192 during office hours, I understand that I (not my insurance company or other carrier) will be charged the full cost of x-rays, \$250 per set. I understand that a valid credit card must be put on file with the office at the time I or my representative/guardian picks up the x-rays to cover such an expense.

I have the right to waive my right to check out my x-rays if I do not agree to the terms listed above.

By affixing my signature below, I agree to these terms.

\_\_\_\_\_

Patient/Guardian Signature

\_\_\_\_\_ Witness (staff only)

\_\_\_\_\_

Date Films Checked Out

Office use only

Credit Card on File

Declined Credit Card on File

Films Returned: \_\_\_\_\_