CHICAGO INSTITUTE FOR HEALTH AND WELLNESS
ANSWERS - OPTIONS - RESULTS

Welcome!

999 West Main Street
West Dundee, IL 60118

Patient's Name_____ Today's Date _____

Address _____ Date of Birth _____

Cell Phone ( )_____ - _____ Phone Carrier (for text confirmations) _____

Home No. ( )_____ - _____ Work No. ( )_____ -_____ Ext. ( )

E-mail Address: _____

Employer: _____ Occupation:_____

Spouse/Significant Other: _____ Marital Status: _____

Emergency Contact: _____ Telephone# ( )_____Ext.( )

How did you hear about us (circle all that apply)? Online Search Healthgrades Website Social Media MSQ

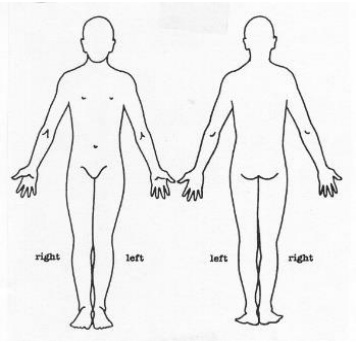
Patient Referral: _____ Physician Referral: _____

Wellness Workshop or Event: _____ Date: _____

Other: _____

Do you experience any of these symptoms daily?

- ○ Fatigue
- ○ Depression
- ○ Shortness of breath
- ○ Insomnia
- ○ Headaches
- ○ Chronic pain
- ○ Constipation
- ○ Diarrhea
- ○ Urinary incontinence
- ○ Itching/ rash
- ○ Panic attacks



Visual Analog Scale

Please place an (X) along the line below which represents your current level of pain involving your major area of complaint.

NO PAIN PAIN

I can **sit** for _____ minutes before symptoms begin.

I can **stand** for _____ minutes before symptoms begin.

Hospitalizations /Surgery _____ Date _____

_____ Date _____

I have been treated for this condition with:_____

GENERAL HEALTH HISTORY

Medical History
- ◊ Arthritis
- ◊ Allergies
- ◊ Asthma
- ◊ Alcoholism
- ◊ Alzheimer's
- ◊ Autoimmune disease
- ◊ Bronchitis
- ◊ Cancer
- ◊ Chronic Fatigue
- ◊ Cholesterol (elevated)
- ◊ Circulation problems
- ◊ Colitis
- ◊ Dental problems
- ◊ Depression
- ◊ Diabetes
- ◊ Diverticular disease
- ◊ Drug addiction
- ◊ Eating Disorder
- ◊ Epilepsy
- ◊ Emphysema
- ◊ Fibromyalgia
- ◊ Food Intolerance
- ◊ Gall Stones
- ◊ GERD
- ◊ Genetic Disorder
- ◊ Glaucoma
- ◊ Gout
- ◊ Heart Disease
- ◊ High Blood Pressure
- ◊ Infection (chronic)
- ◊ Inflammatory Bowels
- ◊ Irritable Bowels
- ◊ Kidney/ Bladder issues
- ◊ Learning Disabilities
- ◊ Liver Disease
- ◊ Mental Illness
- ◊ Migraine Headaches
- ◊ Neurologic Problems
- ◊ Sinus Problems
- ◊ Stroke
- ◊ Thyroid Problems
- ◊ Obesity
- ◊ Osteoporosis
- ◊ STD
- ◊ Skin problems
- ◊ Ulcers
- ◊ Urinary tract infection
- ◊ Varicose veins

Medical (Men)
- ◊ BPH
- ◊ Prostate Cancer
- ◊ Decreased Sex Drive
- ◊ Infertility
- ◊ Other _____

Medical (Women)
- ◊ Menstrual irregularities
- ◊ Endometriosis
- ◊ Infertility
- ◊ Fibroids / ovarian cysts
- ◊ Fibrocystic breasts
- ◊ PMS
- ◊ Breast Cancer
- ◊ Pelvic Inflammation
- ◊ Vaginal Infections
- ◊ Decreased sex drive
- ◊ Other _____
- ◊ Age of 1st period ____
- ◊ Birth control Y N
- ◊ # of children _____
- ◊ # of pregnancy _____
- ◊ C-section Y N
- ◊ Surgical Menopause
- ◊ Menopause
- ◊ Date of last cycle _____
- ◊ Length of cycle _____
- ◊ Change in flow _____

Family Health History (Parents and Siblings)
- ◊ Arthritis
- ◊ Asthma
- ◊ Alcoholism
- ◊ Alzheimer's
- ◊ Cancer
- ◊ Depression
- ◊ Diabetes
- ◊ Genetic Disorder
- ◊ Glaucoma
- ◊ Heart disease
- ◊ Infertility
- ◊ Mental Illness
- ◊ Neurologic disorders
- ◊ Obesity
- ◊ Osteoporosis
- ◊ Stroke

Health Habits
- ◊ Tobacco:

Cigarettes #/day _____
Other _____
- ◊ Alcohol

Drink #/ day _____
- ◊ Caffeine: Coffee / Tea

Cups #/day_____
- ◊ Soda #/day _____
- ◊ Water oz/day _____

Exercise:
# of days / week _____
Average Duration /Min. ___
Type of exercise:
Walk Run Weights Swim Yoga Other _____

Nutrition & Diet
- ◊ Mixed food diet (animal and plant sources)
- ◊ Vegetarian / Vegan
- ◊ Salt restrictions
- ◊ Fat restrictions
- ◊ Carb restrictions
- ◊ Calorie restrictions
- ◊ Specific Food restriction

_____
_____
_____
_____

Current Medications

Name	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Supplements

_____
_____
_____

Would you like to:
- ◊ Have more energy
- ◊ Be stronger
- ◊ Have more endurance
- ◊ Increase sex drive
- ◊ Lose weight
- ◊ Improve complexion
- ◊ Be less depressed
- ◊ Be less moody
- ◊ Improve memory
- ◊ Think more clearly
- ◊ Feel more motivated
- ◊ Not be dependent on pharmaceuticals
- ◊ Sleep better
- ◊ Be pain free
- ◊ Get sick less often
- ◊ Get rid of allergies
- ◊ Reduce family risk factors

Stress Level:

0——————————5——————————10

Major cause of stress
- ◊ Friends
- ◊ Family
- ◊ Finances
- ◊ Work
- ◊ Self induced

Time of Day:
- ◊ Most energy AM PM
- ◊ Least energy AM PM

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Informed Consent/Release of Medical Records/Assignment of Benefits

INFORMED CONSENT: all patients receiving care from a physician must be notified of potential risks/side effects of treatment. Physical medicine involves exercise to joints and muscles that may by sensitive because of lack of use, overuse, or injury. The most common side effect of physical medicine is temporary muscle and joint soreness. Rare side effects may include fracture in individuals taking corticosteriod medications or individuals with osteoporosis. The most remote risk involves vascular damage to the vertebral artery in individuals who have vertebral artery disease (VAD). Symptoms of this disease are dizziness, nausea, vertigo, and unsteadiness when leaning the head back and to one side. If you have ever experienced these symptoms please inform your physician. **By signing below, you acknowledge the above, and you are consenting to undergo the diagnostic procedures and treatments recommended by your physician.**

MEDICAL RECORDS RELEASE:: I authorize the release of information about my treatment to my other health care providers.

IRREVOCABLE ASSIGNMENT OF BENEFITS:In consideration of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to ADVANCED SPORTS MEDICINE SC, or Chicago Chiropractic Group, Ltd., all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges and outstanding balances regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement of any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission.

PATIENT SIGNATURE (or parent of minor)

_____DATE_____