CHICAGO INSTITUTE FOR HEALTH AND WELLNESS
ANSWERS - OPTIONS - RESULTS

THRIVE ABILITY CENTER

Welcome!

Today's Date: _____

Patient Name: _____ DOB: _____

Parent Name (For Minors): _____ Parents Number: (_____)_____

Cell Phone: (_____)_____ Carrier (Needed for Text Reminders): _____

Address: _____ State: _____ Zip: _____

Occupation: _____ E-Mail: _____

Primary Care Dr: _____ Phone: (_____)_____

Emergency Contact: _____ Phone: (_____)_____

How did you hear about us? Patient Walk-In Google Social Media Workshop / Event

Referral; Patient or Physician : _____

Other: _____

What is the reason for your visit today? _____

What caused it? _____ When did it start? _____

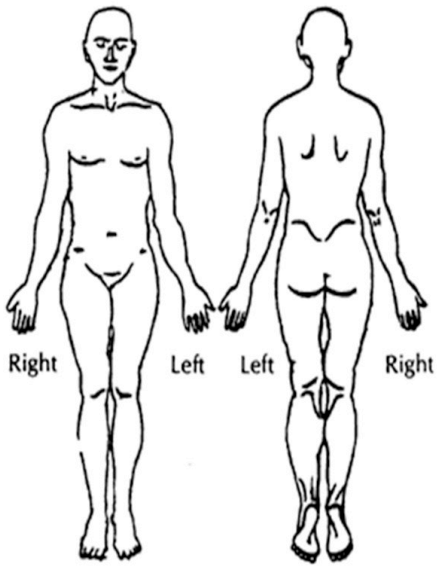
Please select your current pain level below (0 = No Pain, 10 = Worst Pain Imaginable):

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

Please shade in painful spots

Place an X over any areas that have decreased sensation

Place an O over any areas that have increased sensation



999 W. Main Street, Suite 100
West Dundee, IL 60118

Phone: 224-535-8707
Fax: 224-535-8743

MEDICAL HISTORY

- Alcoholism
- Allergies
- Alzheimer's
- Anxiety
- Arthritis
- Asthma
- Autoimmune Disease
- Bronchitis
- Cancer
- Chronic Fatigue
- Circulation Problems
- Colitis
- Dental Problems
- Depression
- Diabetes
- Diverticular Disease
- Drug Addiction
- Eating Disorder
- Epilepsy
- Emphysema
- Fibromyalgia
- Food Intolerance
- Gall Stones
- GERD
- Glaucoma
- Gout
- Heart Attack
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Irritable Bowels
- Kidney Issues
- Learning Disabilities
- Liver Disease
- Mental Illness
- Metal Implants
- Migraines
- Neurological Problems
- Sinus Problems
- Stroke
- Thyroid Problems
  Hypo / Hyper
- Obesity
- Osteoporosis
- Skin Problems
- STD's
- Ulcers
- UTI's
- Varicose Veins
- Other: _____
  _____
  _____
  _____
  _____

MEDICAL (MEN)

- BPH
- Decreased Sex Drive
- Incontinence
- Infertility
- Prostate Cancer
- Other: _____
  _____
  _____

MEDICAL (WOMEN)

- Age of 1st Period: ____
- Birth Control: Yes No
- Breast Cancer
- Breast Implants
- Decreased Sex Drive
- Endometriosis
- Fibroids / Cysts
- Incontinence
- Infertility
- Menopause
- Pelvic Inflammation
- PMS
- Vaginal Infections
- # /Children: _____
- # /Pregnancies: _____
- C-Section: Yes No
- Other: _____
  _____
  _____

PARENTS & SIBLINGS

- Alcoholism
- Alzheimer's
- Arthritis
- Asthma
- Cancer
- Depression
- Diabetes
- Drug Addiction
- Glaucoma
- Heart Attack
- Heart Disease
- Mental Illness
- Neurological Problems
- Obesity
- Osteoporosis
- Stroke
- Other: _____
  _____
  _____
  _____
  _____
  _____

HEALTH HABBITS

- Alcohol Use
  Drinks /Week: ____
- Caffeine Use
  Cups /Day: ____
- Nicotine Use:
  Cigarettes /Day: ____
- Soda /Day: ____ oz.
- Water /Day: ____ oz.

EXCERSIZE

- Days /Week: ____
- Duration /Day: ____
- Type of Exercise:
  Walk Run Yoga
  Bike Weightlifting
  Other: _____
  _____
  _____

NUTRITION / DIET

- Mixed (Plant/Animal)
- Vegetarian
- Vegan
- Gluten Free
- Keto
- Calorie Restrictions
  Per Day _____
- Carb Restrictions
  Per Day _____
- Salt Restrictions
- Fat Restrictions
- Food Allergies: _____
  _____
  _____
- Other: _____
  _____
  _____

ENERGY LEVELS

Most Energy: AM PM
Least Energy: AM PM

STRESS LEVELS

Please Circle One:
0 being none, 10 being extreme

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

In your opinion, what is affecting your stress levels?

_____
_____
_____

YOUR GOALS

- More Energy
- More Endurance
- More Motivation
- Gain Strength
- Be Pain Free
- Sleep Better
- Eat Better
- Lose Weight
- Gain Weight
- Improve Memory
- Reduce Anxiety
- Rid of Allergies
- Rid of Medication

CURRENT MEDICATION, MG & HOW OFTEN:

_____
_____
_____
_____
_____

SURGERIES / DATE:

_____
_____
_____
_____
_____

ALLERGIES / OTHER:

_____
_____
_____
_____
_____

FOR PHYSICAL THERAPY PATIENTS:

Are you enrolled in Home Health Care (HHC): Yes No

Have you had Imagining? Yes No

If yes, of what / results:

_____
_____
_____
_____
_____

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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 and 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 corticosteroid medications or individuals with osteoporosis. The most remote risk involves vascular damage to the vertebral artery in individuals who have vertebral artery disease. 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 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 hereby convey directly to Chicago Chiropractic Group, Ltd., all medical benefits or insurance reimbursement, if any, otherwise payable to me for services rendered from the doctor(s). I understand that I am financially responsible for all charges and outstanding balances regardless of any applicable insurance or benefit payments. I authorize any plan administrator or fiduciary insurer, and my attorney to release all plan documents, insurance policy and/or settlement information upon request in order to claim such medical benefits, reimbursement of any applicable remedies. I authorize the use of this signature on all insurance and/or employee health benefits claim submission.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT / HIPAA

For use and/or disclosure of Protected Health Information (PHI) to carry out Treatment, Payment, and Health Operations

I,_____(Name), hereby state that by signing this Consent, I acknowledge and agree as follows:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The HIPAA Security Rule protects a subset of information covered by the Privacy Rule. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for the Practice to provide treatment to me.

I understand it is necessary for the Practice to obtain payment for my treatment and carry out personalized health care operations. I also understand that the Practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with the law.

The Practice's Privacy Notice is provided at the time of the patient's first visit and they have further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Notice carefully prior to my signing this Consent. I know it is always available with the staff at the reception desk. I may also request a copy from this office at any time via US Mail.

I have read and understand the forgoing notice and all my questions have been answered to my complete satisfaction in a way that I can understand.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

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CANCELLATION POLICY

Dear Valued Patients,

Thank you for choosing our practice for your health and wellness needs; we appreciate your confidence in our care. It is important to us that you are aware of all office policies and procedures so please read the following policy carefully: **By signing this document you agree to give our office at least a 24-hour notice prior to your appointment time if you are unable to keep said appointment**. This not only gives another patient the opportunity to be seen but also allows our staff to utilize their time most efficiently.

Appointments require time and preparation of the chiropractic physician, physical therapists, massage therapists, and the support staff. Our schedule is designed to accommodate the needs of all patients.

Any missed appointments without adequate notice will result in a charge of $50.00 to your account. We understand emergencies can come up; please let us know immediately when you are unable to keep an appointment due to unexpected circumstances and we can further assist you.

We appreciate your understanding and acknowledgement of this policy.

Sincerely,

The Chicago Institute for Health and Wellness / Thrive Ability Center Staff

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

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