

Patient's name: _____
Date of Birth: ____/____/____

Today's Date: _____

Your Address:

Street _____ City _____ State _____ Zip code _____

Home Telephone# () _____ - _____

Work Telephone# () _____ - _____ Ext. () _____

(Cell) Phone () _____ - _____

E-mail Address: _____

Occupation: _____

Employer: _____ Phone #: _____

Spouse/Significant Other: _____

Marital Status: _____

Emergency Contact:

Name: _____

Telephone# () _____ - _____ Ext.() _____

Please Provide Insurance Card & Identification

Primary card holder: (If different from above)

Name: _____

DOB: ____/____/____

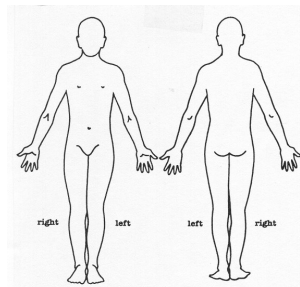
Insurance Co. _____

Phone # _____ Policy #: _____

Group #: _____

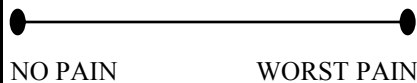
Symptom Chart

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols shown below.



Visual Analog Scale

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



Do you experience any of these symptoms daily?

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

Hospitalizations /Surgery

Date

_____	_____
_____	_____
_____	_____
_____	_____

Chief Complaint Information

I am here today because: _____

My symptoms began: _____

It was ____ sudden or ____ gradual?

My condition is related to an injury: (car accident, work related, sports, a fall, or other) _____

My condition is hindering my activities at work/ home. If so which? _____

These are my symptoms. (please describe)

I was engaged in when my symptoms started:

My symptoms are worse:

____ Morning ____ Later in the Day ____ at Night ____ Always Same

My pain is:

____ Burning ____ Electric Shock ____ Sharp ____ Shooting
____ Stabbing ____ Dull Ache ____ Other _____

I have had this previously. If so when?

My symptoms are better during: (position, activity)

My symptoms are worse during: (position, activity)

Aggravating Factors:

____ Lifting ____ Standing ____ Climbing Stairs ____ Movement
____ Walking ____ Driving ____ Sitting ____ Coughing
____ Sneezing ____ Arm Overhead ____ Straining at Bowels
____ Other _____

I am experiencing my symptoms:

____ Every Day ____ Frequently ____ Occasionally ____ Rarely

My symptoms are:

____ Constant ____ Intermittent ____ With Activity ____ Sleep Disturbed

The intensity of my pain is: 0— 10 (10 is worst) _____

My pain stops me from walking certain distances:
Distance? _____

I can sit for _____ minutes before symptoms begin.

I can stand for _____ minutes before symptoms begin.

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

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 be 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 (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)

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



DATE _____