



440 Quadrangle Drive Ste. F
Bolingbrook, IL 60440
Phone: 630.771.1212

New Patient Intake Form

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

We use text messaging for appointment reminders. Who is your cell phone carrier? _____

Email Address: _____ Male: ____ Female: ____

Birth Date _____ Age: _____

Have you seen a Chiropractor before? Yes No If yes, when? _____

Where did you hear about us? Google ____ Facebook ____ Zocdoc ____ Friend/Family/Coworker ____ Other _____

YOUR HEALTH SUMMARY CHECK ALL THAT APPLY:

- | | | |
|---|--|---|
| ☐ Headaches | ☐ Numbness in Fingers | ☐ Diarrhea |
| ☐ Pins and Needles in legs | ☐ Numbness in toes | ☐ Constipation |
| ☐ Fainting | ☐ Loss of Taste | ☐ Fever |
| ☐ Neck Pain | ☐ Stomach upset | ☐ Hot Flashes |
| ☐ Pins and Needles in Arms | ☐ Fatigue | ☐ Cold Sweats |
| ☐ Loss of Smell | ☐ Depression | ☐ Lights bother eyes |
| ☐ Back Pain | ☐ Irritability | ☐ Problem Urinating |
| ☐ Loss of Balance | ☐ Tension | ☐ Heartburn |
| ☐ Dizziness | ☐ Sleeping Problems | ☐ Mood Swings |
| ☐ Buzzing in ears | ☐ Neck Stiff | ☐ Menstrual Pain |
| ☐ Ringing in ears | ☐ Cold Hands | ☐ Menstrual Irregularity |
| ☐ Nervousness | ☐ Cold Feet | ☐ Ulcers |

List any medication you are taking: _____

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic. I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive. I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedure prescribed for my condition and for any future conditions for which I seek treatment. This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability. _____ The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most **closely** describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
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3. Personal Care (washing, dressing, etc.)

No Pain No restrictions	Mild Pain; Need to go slowly;	Moderate Pain; Need some assistance	Moderate Pain; need 100% assistance	Severe Pain
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4. Travel (driving, etc.)

No pain long trips	Mild pain long trips	Moderate pain long trips	Moderate pain short trips	Severe pain short trips
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5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
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6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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7. Frequency of Pain

No pain	Occasional pain; 25% of day	Intermittent pain; 50% of day	Frequent pain; 75% of day	Constant pain; 100% of day
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8. Lifting

No pain w/heavy weight	Increased pain w/heavy weight	Increased pain w/moderate weight	Increased pain w/light weight	Increased pain with any weight
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9. Walking

No pain any distance	Increased after 1 mile	Increased after 1/2 mile	Increased after 1/4 mile	Increased all walking
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10. Standing

No pain after several hours	Increased after several hours	Increased after 1 hour	Increased after 1/2 hour	Increased w/any standing
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Name _____

PRINTED

Signature

Date

Consent Form

Consent for Treatment

I, the undersigned, a patient at Achieve Health and Wellness, hereby authorize any and all chiropractic practitioners of Achieve Health and Wellness to administer chiropractic treatment as needed. I understand that each individual case is unique so there have been no guarantees regarding the results that may be obtained while under care. I understand that if the chiropractic physician feels it necessary, he/she will take the x-rays needed to better understand my condition. I understand that he/she will inform me of any abnormal, non-chiropractic, finding that he/she finds, if any.

Authorization for Treatment of a Minor (if applicable)

I authorize any and all chiropractic practitioners of Achieve Health and Wellness to administer treatment and x-rays, as needed, to my child _____, I understand that x-rays will only be taken in the event of a trauma and not as part of a routine initial exam for a child under 13 years of age.

Financial Responsibility-Insurance Payment

I, understand that, as a courtesy to me, Achieve Health and Wellness may file my insurance according to the particulars of my policy. If so, I authorize my insurance carrier(s) to make a payment for the expense benefits allowed and otherwise payable to me, directly to Achieve Health and Wellness for professional services I have received while under care at Achieve Health and Wellness. I agree to pay, in a current manner, any balance of said professional charges. I also authorize the release of any medical information necessary to process my insurance claims and to verify that all insurance information provided to this office is accurate and complete. If my insurance policy does not cover services rendered from this office, then I am responsible for the non-covered services at the time they were rendered.

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payments/co-insurance, and any services rejected by my insurance company.

Financial Responsibility- Cash Patients

I agree to be financially responsible for **all** charges incurred at this clinic, and understand that all charges are to be paid in full at the time of service, unless prior financial arrangements have been made with this office. If I do not currently have insurance, or if I do not have insurance coverage at any point in the future, I agree to pay all charges incurred. I will notify Achieve Health and Wellness if I have difficulty making appropriate payments, so that a payment plan can be created.

Authorization to Release Medical Information- health insurance/personal injury

I authorize Achieve Health and Wellness to request any and all medical records related to my condition from other health providers. If I am involved in a personal injury case now or at any point in the future, I authorize Achieve Health and Wellness to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and, hereby, release Achieve Health and Wellness of any consequence thereof. In addition, I authorize the insurance company, adjustor, and/or attorney to release payment for services rendered directly to Achieve Health and Wellness.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

AUTHORIZATION AND RELEASE FORM FOR USE IN MARKETING MATERIALS

I, the undersigned, have agreed to voluntarily: [patient to initial those that apply]

- Appear in a photo as a patient of the doctor or clinic _____
- Provide written material, including but not limited to a rating, testimonial, endorsement, or description of experience with this doctor and clinic _____
- Appear in a video testimonial for this doctor and clinic _____
- Allow the use of my _____ initials or _____ name in connection with the above

I understand that the physician and clinic named above may use these materials that may include my initials, name, portrait, picture, electronic image, video, voice or likeness. I further understand that the physician and clinic may publish these materials for commercial, marketing and promotional purposes, and may post the materials on various platforms on the Internet, including but not limited to the practice's website, related websites, and social media; or the physician or clinic may produce and distribute the materials in hard copy; and/or otherwise publish and distribute the materials.

I understand that the information contained in these materials, including the fact that I am a patient of the doctor and clinic, as well as information relating to my medical condition, diagnosis, and treatment, contains protected health information (PHI) that, without this authorization, would be confidential under HIPAA. With that knowledge and full understanding of my right to confidentiality, I voluntarily consent to and authorize the doctor and clinic to publish the information I have provided, to the extent of the information I have disclosed in the testimonial. This authorization remains in effect until the first to occur of my written revocation or three years after my last visit to the doctor and clinic.

I understand that this Authorization is limited to the materials that I have initialed above and that this Authorization does not eliminate my HIPAA rights with regard to any other of my protected health information.

I also acknowledge and understand my right to control the commercial use of my likeness and other identifiers, such as my initials, name, portrait, picture, electronic image, video, voice or likeness. I understand that the Illinois Right of Publicity Act (765 ILCS 1075/30) requires my previous written consent to use my identity for commercial purposes during my lifetime. With that knowledge, I agree to release and discharge the physician and clinic from any and all liability for use or disclosure of any information, any claims for invasion of privacy, claims for use of intellectual property, claims for compensation, or any other claim based on the use of the electronic material specified above.

By signing this document, I acknowledge that I am 18 years of age or older; that I have read the document; that it has been provided to me to clarify the intended use of the electronic, photographic, and textual material; that any questions have been answered regarding its use; and that I am participating in the production and am signing this document freely, voluntarily and without coercion or duress.

- **I would like to decline all the above (Initial here) _____**

Printed Name: _____

Patient Signature: _____

Date: _____