339 N. Schmidt Rd.
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? _____

YOUR HEALTH SUMMARY CHECK ALL THAT APPLY:

___Headaches
___Pins and Needles in legs
___Fainting
___Neck Pain
___Pins and Needles in Arms
___Loss of Smell
___Back Pain
___Loss of Balance
___Dizziness
___Buzzing in ears
___Ringing in ears
___Nervousness
___Numbness in Fingers
___Numbness in toes
___Loss of Taste
___Stomach upset
___Fatigue
___Depression
___Irritability
___Tension
___Sleeping Problems
___Neck Stiff
___Cold Hands
___Cold Feet
___Diarrhea
___Constipation
___Fever
___Hot Flashes
___Cold Sweats
___Lights bother eyes
___Problem Urinating
___Heartburn
___Mood Swings
___Menstrual Pain
___Menstrual Irregularity
___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

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back 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

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

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

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

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. including any extra charges for x-rays 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:_____