

Patient Name:		Date:			
Address		City		State	Zip Code
H. Phone	W	V.Phone		Cell Phone	
Email Addı	ess:				
Sex M	F Marital Status M S D W	Date of Birth_		Age	
Social Secu	rity #		-		
Referred by	/:		-		
	ver received Chiropractic Care?				
Primary rea					
	ealth History:				
 A. Please indicate if you have a history of any of the following: Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems Lung problems/shortness of breath Cancer Diabetes Psychiatric disorders Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other None of the above 					
B.	Previous Injury or Trauma:				
	Have you ever broken any bon	es? Which?			
C.					



Patient	Name:	Date:			
	D. Medications:				
Medication		Reason for taking			
	E. Surgeries:				
	Date	Type of Surgery			
	F. Females/ Pregnancies and outcome	s:			
	Pregnancies/Date of Delivery	Outcome			
4. Far	nily Health History:				
		Headaches 🗆 Cardiac disease 🗆 Neurological diseases c disease below age 40 🔅 Psychiatric disease 🗆 Diabetes			
	in immediate family:				
Cause of parents or siblings death		Age at death			
Social a	nd Occupational History:				
А.	Job description:				
B.	Work schedule:	·			
C.	Recreational activities:				
D.	Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):				



Patient Name:	Date:
Review of Systems	
Have you had any of the following pulmonary (lung-related) issues?	□ None of the above
Have you had any of the following cardiovascular (heart-related) issues or proce □ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irreg □ None of the above	Heart attacks/MIs 🗆 Heart
Have you had any of the following neurological (nerve-related) issues? □ Visual changes/loss of vision □ One-sided weakness of face or body □ Histor feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertig □ Strokes/TIAs □ Other □ None of the above	ry of seizures □ One-sided decreased o □ Loss of sense of smell
Have you had any of the following endocrine (glandular/hormonal) related issue □ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacement therapy □ Injectable steroid replacement therapy □ Other □ None of the above	
Have you had any of the following renal (kidney-related) issues or procedures? □ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't c □ Difficulty urinating □ Kidney disease □ Dialysis □ Other	
Have you had any of the following gastroenterological (stomach-related) issues □ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdomina □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Ble □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn	l pain □ Hiatal hernia □ Constipation oody or black tarry stools
Have you had any of the following hematological (blood-related) issues? Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosy Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hypercoagulation or deep venous thrombosis/history of blood clots Anticoag Other © None of the above	🗆 Hemophilia
Have you had any of the following dermatological (skin-related) issues?	□ Other □ None of the above
Have you had any of the following musculoskeletal (bone/muscle-related) issues □ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fra □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other	acture
Have you had any of the following psychological issues? □ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Psychiatric hospitalizations □ Other □ None of the above	□ Homicidal ideations □ Schizophrenia
Is there anything else in your past medical history that you feel is important to your	r care here?
I have read the above information and certify it to be true and correct to the best of office of Chiropractic to provide me with chiropractic care, in accordance with this billed, I authorize payment of medical benefits to Health On Earth Wellness Center	state's statutes. If my insurance will be

Patient or Guardian Signature _____ Date_____



Patient Name: _____

Date:

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

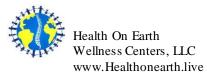
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient of Representative

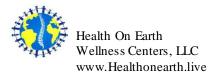
Date

Printed Name

13657 S. Cicero Ave Crestwood, IL 60445



Patient Name:	Date:				
Symptom 1	NEW PATIENT HISTORY FORM Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.				
•	On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10				
•	What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100				
•	When did the symptom begin?				
•	 What makes the symptom worse? (circle all that apply): Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):				
•	What makes the symptom better? (circle all that apply): • Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):				
•	Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe):				
•	Does the symptom radiate to another part of your body (circle one): yes no • If yes, where does the symptom radiate?				
• Symptom 2	Is the symptom worse at certain times of the day or night? (circle one) • Morning Afternoon Evening Night Unaffected by time of day				
•	On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10				
•	What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100				
•	When did the symptom begin?				
•	 What makes the symptom worse? (circle all that apply): Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, twisting left at waist, twisting position, lifting, any movement, driving, walking, running, nothing, other (please describe): 				
•	What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): 				
•	 Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): 				
•	Does the symptom radiate to another part of your body (circle one): yes no o If yes, where does the symptom radiate?				
•	Is the symptom worse at certain times of the day or night? (circle one) • Morning Afternoon Evening Night Unaffected by time of day 5				



Patient Name:	
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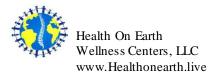
Date: _____

Symptom 3

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? __
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate?
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ___
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day



Patient Name: _____

Date: _____

Symptom 5

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? __
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 6 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ___
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin?
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ______
- Is the symptom worse at certain times of the day or night? (circle one)
 - 0 Morning Afternoon Evening Night Unaffected by time of day



Patient Name: _____

Date: _____

As a society we are 50th in the world in health care. We take pride in helping people attain their optimum health and wellness. With that being said we need an honest assessment of your current level of health. So please place an "X" on the scale below, indicating your level of health and wellness at this time. Then place a star(*) on the diagram, showing us the desired location of your health and wellness.

Very challenged	Challenged	Transition	Good	Excellent
0-50	50-75	75-100	100-125	125+

It has been shown that daily lifestyle stress significantly impacts overall health and wellbeing. As a family wellness office we specialize in removing the cause of your health challenges. We also focus on teaching you how to manage the lifestyle stress es that prevent you from realizing your optimum health and wellness.

Please rate the following **and** checkmark **ALL** answers that apply to your habits: (1 being very poor and 10 being excellent)

Eating habits: ____

- \Box I eat 3-5x's a day
- \Box I eat fruits and vegetables daily.
- \Box I eat out 2-3 times weekly (min)
- □ I drink 3-5 sodas weekly
- \Box I crave sweets.
- \Box I don't watch what I eat.

Sleep:_

- □ I sleep 7-9 hours/night
- □ I wake up well rested
- \Box I wake up tired.
- □ I toss and turn.
- \Box I stay up late.

General Health:

- \Box I am not on medications.
- \Box I take care of myself.
- \Box I watch what I eat.
- \Box I base my health on how everyone around me is doing.
- □ I think I am healthy but know I could make some changes.

On a scale of 1-10 describe your psychological/emotional stress levels:

(1= none/ 10=extreme) Occupational: _____

Personal:

Your Goals

At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. So that we can help you achieve your optimum health it is important that we understand your goals for your overall health and wellbeing.

Exercise habits:___

□ I exercise 3-5 times a week.

- □ I walk daily.
- \Box I don't exercise.
- \Box I want to exercise.
- □ I sit at computer 6-8 hours/day

Mind Set:___

- \Box I have a positive outlook.
- \Box I have a negative outlook.
- \Box I am always in a bad mood.
- \Box I am always in a good mood.
- \Box I trap things inside.
- \Box I share easily.



 Patient Name:
 Date:

Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutritional/Biochemical Goals	Psychological Goals

If there is a need for dietary changes would you like to know?	□ Yes □ No
If there is a need for specific exercises would you like to know?	□ Yes □ No
If there is a need for support in the psychological, mind-body or stress management dimensions of health would you like assistance?	□ Yes □ No
YOU ARE ALMOST THERE! HAVE YOU EVER:	
Bought bottled water:	🗆 Yes 🗆 No
Belonged to a health club:	\Box Yes \Box No
Consumed vitamins or supplements	🗆 Yes 🗆 No
Eaten organic foods?	🗆 Yes 🗆 No
Started a diet program?	🗆 Yes 🗆 No
Gotten more than 6 massages in a year?	\Box Yes \Box No