Whom may we thank for referring you to this office → ________________________________?

APPLICATION FOR CARE AT DUPAGE HEALTHCARE, LTD

Today's Date: ________________

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female

Address: ________________________________ City: ______________________________ State: _____ Zip: ____________

E-mail Address: ______________________________ @ ____________ ☐ Gmail ☐ Comcast ☐ yahoo ☐ sbcglobal ☐ AOL

Home Phone: ____________________ Mobile: ________________________ Work: ____________________________

First and Second Preferred contact method: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Widowed Do you have Insurance: ☐ Yes ☐ No ☐ HMO

Name of Person Who Carries Insurance: ________________________________ Date of Birth **Insured**: __________________

Secondary Insurance: _____________________ Name of Person Who Carries Secondary: ________________ DOB: __________

Social Security #: ______________________________ Driver's License #: ____

Employer: ________________________________ Occupation: ____

Spouse's Name ___________________________________ Spouse's Employer ____

Number of children and Ages: ____

Name & Number of Emergency Contact: _____________________________________ Relationship: _______________________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office and circle the level of pain you are in.
10=worst Pain **0**=no pain

1. ___________________________ **Primary** complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
2. ___________________________ **Second** complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
3. ___________________________ **Third** complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
4. ___________________________ **Fourth** complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is your problem the result of ANY type of accident car, work, or other accident? ☐ Yes ☐ No

How did the injury happen? ____

When did the problem(s) begin? _______________ When is it at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

Is your problem ☐ constant? ☐ Comes and goes during the day? ☐ Comes and goes throughout the week?

Has your condition(s) ever been treated by anyone in the past?

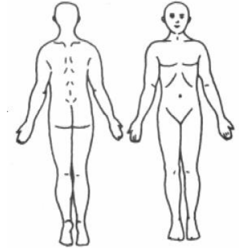
☐No ☐ Yes **If yes,** when: _________________________ by whom? ____

DuPage Healthcare, Ltd

Patient Name____

Name of Previous Chiropractor: ____________________ _____ N/A

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:



P=Pain **R =** Radiating or shooting pain **N =** Numbness **T=** Tingling

What relieves your symptoms? ______________________________

What makes them feel worse? _______________________________

PAST HISTORY

	Explain	Date
SURGERIES		

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → how often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Exercise? What? ______________________________ ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _________________________

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Rising from sitting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform

DuPage Healthcare, Ltd

Patient Name____

Please mark: P=Past **C=**currently or **leave blank**=Never

	Headaches		Bed Wetting		Frequent Illness		Heartburn		Digestion Problems		Balance Problems
	Neck Pain		Hip Pain		Epilepsy		Dizziness		Diarrhea/Constipation		Vision Problems
	Low Back pain		Pregnant		Tremors		Ulcers		Menopausal Problems		Asthma
	Shoulder Pain		Scoliosis		Chest Pain		ADD/ADHD		Menstrual Problems		Difficulty Breathing
	Mid Back Pain		Swollen Joints		High Bld Pressure		Depression		Trouble Sleeping		Kidney Problems
	Hip Pain		Knee Pain		Sinus/Allergies		Anxiety		Eating Disorder		Liver Problems
	Sciatic		Foot Pain		Skin Problems		Mood Changes		Trouble Losing Weight		Hepatitis A,B,C
	Pain into arms or hands		Numbness or Tingling in legs or feet		Numbness or Tingling in arms or hands		Hearing Problems		Pain with coughing or sneezing		Gall Bladder Problems

List all medications you are taking. This information is an important part of your health history and diagnosis.

Prescription and Non-Prescriptio	How Long?	Why are you taking them?	Noticeable Side Effects
1.			
2.			
3.			

I hereby authorize payment to be made directly to DuPage Healthcare, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to DuPage Healthcare, Ltd. for any and all services I receive at this office.

____ ______ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

DuPage Healthcare, Ltd

Patient Name____

Allowing us to understand all aspects of your past and present history gives us the tools we need to provide you with the best treatment plan, diagnosis, and care possible. Please fill out the relevant information below.

INITIAL NERVE SYSTEM PROFILE

- When was your most recent auto accident? ____
  - Where you injured: ☐No ☐ Yes Where?____
  - Was treatment received? Please describe ____
- When was your most recent strain / stress at work? ____
  - Please describe the manner of the injury ____
  - Was treatment received? Please describe ____
  - Does your job require you remain in long term stressful postures? ______________________________ (*i.e. all day seating, repeated lifting, long term computer use)*
- Spinal traumas in the past? ____
  - Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field____
  - Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident____
  - Work around the house – lifting, bending, woke up with stiff neck, "back went out" ____

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? ☐No ☐ Yes Values? _____________

Have you tested with high blood pressure? ☐No ☐ Yes

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? ☐No ☐ Yes
Do you eat breakfast daily from Monday to Friday? ☐No ☐ Yes _______

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (Circle all that apply)

☐ Diet Soda ☐Coffee ☐Juice ☐ Milk ☐ Soda ☐Alcohol

DuPage Healthcare, Ltd

Patient Name____

INITIAL FITNESS PROFILE

- How many times per week do you exercise?
    - Cardiovascular: _____Hours _____Days or Week
    - Weight Training: ____Hours _____Days or Week
    - Low Impact (Yoga, etc.) ____Hours _____Days or Week
    - If you don't work out-Why? ☐ no time ☐ hurts ☐ don't like it ☐ Other: _______________

- What is your target weight? ____________What is your current weight? __________
- Would you like our help reaching your goal weight? ☐No ☐ Yes

INITIAL TOXICITY PROFILE

- Are you regularly exposed to cleaning products or industrial chemicals? ☐No ☐ Yes
- Have you ever noticed mold growing in your home or your place of work? ☐No ☐ Yes
- Do you receive yearly flu shots? ☐No ☐ Yes
- Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? ☐No ☐ Yes

INITIAL STRESS PROFILE

- Do you get an average of 8 hours of sleep per night ☐No ☐ Yes
- Do you ever take pills to go to sleep or relax ☐No ☐ Yes
- Do you often feel short on time and procrastinate on projects? ☐No ☐ Yes
- Do you experience feelings of anxiety about completing tasks? ☐No ☐ Yes
- Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)
- Do you rely more on your memory than a planner and action list to get things done? ☐No ☐ Yes
- Do you take time to pray, meditate, or visualize on a regular basis? ☐No ☐ Yes

DuPage Healthcare's Policies

DHC Copy

Informed Consent

Patient initials: __________

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at DuPage Healthcare have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout

Notice Regarding Your Rights To Privacy

Patient initials: __________

I have received a copy of DuPage Healthcare's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Office Policies

Patient initials: __________

I hereby acknowledge receiving a copy of the practices 'Office Policies' This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

____ ______________

Patient's Name DOB

____ ______________

Patient or authorized person's signature Date

____

DuPage Healthcare Witness

DuPage Healthcare NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call DuPage Healthcare at (815) 372-0170. If she/he is unavailable, you may make an appointment with our receptionist to see her /him within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient Copy

ADMINISTRATIVE- NOTICE OF- OFFICE POLICIES

OUR OFFICE POLICIES

Welcome to DuPage Healthcare

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care*,** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **DuPage Healthcare** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use 1)Clear Institute OR 2) a myriad of techniques to accomplish this goal, including but not limited to Diversified, Gonstead, Upper Cervical, Logan Basic, Activator. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.