Welcome to HealthStyle Chiropractic and Wellness

First Name:_____ MI:___ Last Name:_____ DOB:_____ Age:_____
Address:_____ City:_____ State:_____Zip:_____
Gender:_____ # of Children:_____ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Email:_____
Home #_____ Cell #_____ Work #_____
Employer:_____ Occupation:_____
Spouse (parent if under 18):_____ Spouse DOB (parent if under 18):_____
Who may we thank for referring you?_____

Your Health Profile

Please Circle any condition you currently have or have had in the past

Numbness/Tingling/Pain in (arms / hands / fingers) R L Both		Numbness/Tingling/Pain in (buttocks/legs/feet/ toes) R L Both	
Headaches / Migraines	Hip Pain R L Both	Neck Stiffness / Pain	Back Stiffness / Pain
Fractured Bones	Arthritis	Frequent Colds / Flu	Diabetes
Swollen Painful Joints	Convulsions / Epilepsy	Skin Problems	Fertility Problems
Anemia	Tremors	Blurred Vision R L Both	Double Vision R L Both
Pain with Cough / Sneeze	Chest Pain	Lung Problems	Loss of Taste
Heart Problems	Stroke	Gall Bladder Problems	Digestive Problems
Prostate Problem	Kidney Trouble	Loss of Smell	Loss of Balance
Dizziness / Vertigo	Buzzing / Ringing in Ears	Sinus Problems / Allergies	Nervousness / Anxiety
Fatigue	Depression	Irritability / Mood Swings	Tension / Stress
Colon Trouble	Sleeping Problems	Hot Flashes	Stomach Upset
Cold Feet	Bed Wetting	Cold Hands	Diarrhea / Constipation / Gas
Foot Problems	Asthma / Shortness of Breath	Recurring Infections	Jaw / TMJ Pain
Cold Sweats	Light Bothers Eyes	Problems Urinating	Heartburn / Reflux
High Blood Pressure	PMS	Menopause	Ulcers
Cancer (Type) _____	Other _____		

Additional Explanation:_____

Primary Complaint:_____
When did the condition begin?_____ Has it ever occurred before? Yes No

Type of Pain: (circle all that apply)

Pain Numbness Swelling Muscle Spasm Headache Tightness Stiffness
Tingling Weakness

Quality of Pain: (circle all that apply)

Sharp Dull Aching Throbbing Crushing Stabbing Local Radiating
Burning Migraine Tension Hormonal Sinus Organ Dysfunction Other

Is there anything that makes it better?_____
Is there anything that makes it worse?_____

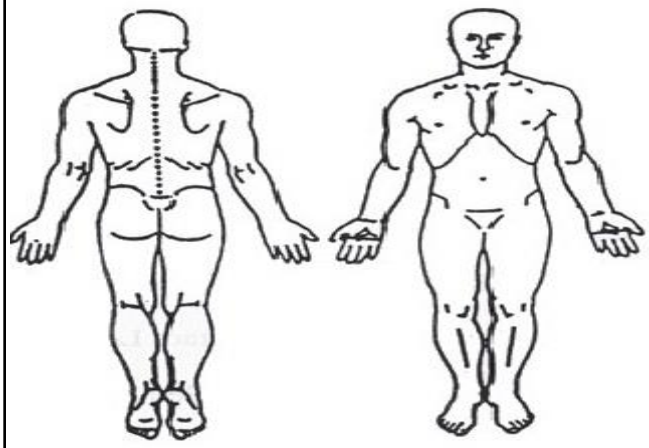
Severity: Please circle a level from 0 (no pain) to 10 (disabling pain)
0 1 2 3 4 5 6 7 8 9 10
Does the pain radiate? If so, where?_____

Timing: (mark all that apply)
Is the pain: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ Infrequent
Is the pain worse in: ☐ Morning ☐ Midday ☐ Night ☐ Consistent all day

Daily Activities:
Please write a number from 0 (no pain) to 10 (diabling pain) on each line below (write N/A if not applicable)

Bending _____	Carrying _____	Climbing Stairs _____
Concentrating _____	Dancing _____	Doing Chores _____
Computer Work _____	Dressing _____	Driving _____
Gardening _____	Lifting _____	Playing Sports _____
Pushing/Pulling _____	Reading _____	Rolling Over _____
Running/Jogging _____	Shoveling _____	Sitting _____
Sit to Stand _____	Sleeping _____	Standing _____
Walking _____	Watch TV _____	Working _____

Please **MARK** on diagram areas of discomfort



Please list the past **4 traumas** you have experienced (any and all of the following: auto accidents, falls, concussions, broken bones, childhood injuries, surgeries, etc.) and approximate date:

1. _____ 3. _____
2. _____ 4. _____

Impact of Your Symptoms: How is this Symptom/Condition interfering with your life? (Check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	Other	☐	☐	☐	☐

What solutions have you tried to solve this problem? _____

Have you been to a Chiropractor before? Y / N If yes, did you get Corrective Care? Y / N
Doctor's Name/Location: _____ Date of last visit: _____

Any Other **Complaint/Conditions** that the Doctor should address? If so, list & describe: _____

_____

Medications: What are you currently taking and why? _____

_____

What is your objective(s) in coming to our office: ☐ Family Wellness ☐ Corrective Spinal Care ☐ Symptom Relief

Commitment: Please Circle the level that corresponds with your level of commitment to your overall Health and Wellness

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

_____

I hereby certify the statements and answers given on this form are accurate to the best of my knowledge. I agree to allow this office to perform an evaluation.

Signature: _____ Date: _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the scientifically specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during your course of a chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference t other expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have read and fully understand the above statements. I therefore begin my chiropractic examination and any further care on this basis.

I, _____ have read and fully understand the above statements.

_____ _____

(Signature) (Date)

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

(Signature) (Date)

HealthStyle Chiropractic and Wellness
533 W. North Ave. Ste 202
Elmhurst IL, 60126
630-433-2442
www.healthstylewellness.com

HIPPA Practice Requirements

(A) The practice is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your PHI.

(B) Under the Privacy Rule, the practice may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(C) The practice is required to abide by the terms of this notice

(D) The practice reserves the right to change the terms of this Privacy Notice and to make new provision effective for your entire PHI that it maintains.

(E) The practice will distribute a revised Privacy Notice to you prior to implementation if changes become necessary.

(F) The practice will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is in effect as of April 15th, 2003

STATE LAW

A copy of HIPPA laws will be available to me at any time for my review, and a copy will be given to me upon my request.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date