New Condition Intake Form

Chiropractic Centre of Highland Park

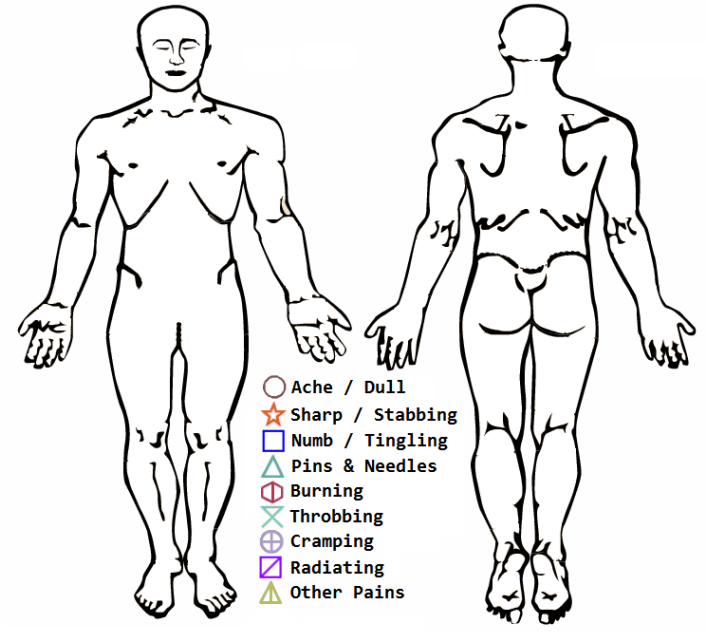
210 Skokie Valley Road #7 , Highland Park, IL 60035

Phone: 847.831.5252

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	◯ Male ◯ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Patient Symptoms:



Reason for this Visit:

Describe the reason for this visit?

When did this concern begin? _____ Has this concern: ○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ○ Yes ○ No

Briefly Explain: _____

Have you seen other doctor's for this concern? ○ Yes ○ No Doctor's name: _____

Type of Treatment: _____

Complaint Information:

Injury Occurred: ○ Work ○ Automobile ○ Third-Party ○ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Interfere w/ Activities: ○ Yes ○ No Affected Sleep: ○ Yes ○ No Frequency: _____

Missed Work: ○ Yes ○ No Unable to Work from: _____ Unable to Work Until: _____

Affected Appetite: ○ Yes ○ No Explain: _____

Reduced Work: ○ Yes ○ No Explain: _____

Does it Worsen: ○ Yes ○ No Explain: _____

Weather Affects it: ○ Yes ○ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ○ Yes ○ No Explain: _____

X-rays Taken: ○ Yes ○ No Explain: _____

Same Condition Before: ○ Yes ○ No Date: _____ Practitioner: _____

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date: _____

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210 Skokie Valley Road #7, Highland Park, IL 60035
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Fax: 847.831.5272

Electronic Health Records Intake Form

First Name: _____ **Last Name**: _____

Email address: _____@_____ Cell Number:_____

Preferred method of communication for reminders (Circle one): Email / Text (Cell Provider = _____)

DOB: ___/___/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Are you currently taking any medications? (Please list prescription & non-prescription medication and supplements) Use back of page or attach additional sheets if necessary.

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? (Indicate if N/A)

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____