Restoration Health & Chiropractic
365 E. Bailey Rd.
Naperville, IL 60565
(630) 506-7758

New Patient Intake Form

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician **Restoration Health & Chiropractic** and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with **Dr. Colleen Fazio** and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

_____/_____/_____
Date

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

_____
Print Name of Representative

_____
Signature of Representative

_____/_____/_____
Date

Physician Signature _____ Date _____/_____/_____

Restoration Health & Chiropractic
365 E. Bailey Rd.
Naperville, IL 60565
(630) 506-7758

New Patient Intake Form

PATIENT INFORMATION

First Name _____Middle_____ Last _____
Date of Birth_____/_____/_____ Sex M F Married ◊ Single ◊ Other ◊

Address_____ Email _____

City_____ State_____ Zip_____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____ Work Phone (_____)_____-_____

In what City were you Born? _____

Occupation_____ Employer's Name_____

Emergency Contact_____ Phone (_____)_____-_____

INSURANCE INFORMATION

Do you have insurance which covers chiropractic treatment? YES NO (If NO skip this section)

Insurance Company_____

Plan ID #_____Group #_____

Insurance Company Address_____ City_____ State_____ Zip_____

Primary insured same as patient? YES NO (If yes then skip next 3 lines)

Patient Relationship to Insured Self Spouse Child Other

Insured Name_____ Insured Address_____

Insured D.O.B._____/_____/_____ Insured Gender M F Insured Phone (_____)_____-_____

ACCIDENT/ILLNESS INFORMATION

Is this condition related to: Employment YES NO

Auto Accident YES NO

Other Accident YES NO

Date of Accident _____/_____/_____ Dates missed from work_____

How did you hear about Restoration Health & Chiropractic? _____

Physician Signature _____ Date _____/_____/_____

Restoration Health & Chiropractic
365 E. Bailey Rd.
Naperville, IL 60565
(630) 506-7758

History

Patient Name_____ Date_____/_____/_____

Height: _____ Weight: _____ Blood Pressure: _____

List any **past diseases** including those from childhood _____

_____

_____

_____

_____

List any **surgeries**, major **traumas** (including concussions and broken bones), illnesses, recent immunizations, or other hospitalizations_____

_____

_____

Have you ever been diagnosed with a splondylolisthesis, compression fracture, or other spinal fracture?

_____

List any medical **allergies** _____

_____

List all **medications** you are currently on or have recently taken_____

_____

List all **vitamins** or other supplements you currently take_____

_____

_____

Have you **family** members suffered from any diseases such as heart disease, diabetes, cancer, or any other inherited disease? If so, please list_____

_____

What is your occupation? _____

What are your hobbies/recreational interests? _____

YES NO Are you currently taking NSAIDS (Ibuprofen, Acetaminophen, etc) How often? _____

YES NO Do you drink alcohol? If yes how many drinks and how often? _____

YES NO Do you smoke? How many packs a day? _____ How many years? _____

YES NO Do you exercise on a regular basis? How? _____

YES NO Do you eat fast food more than 3 times a week? How often? _____

YES NO Do you drink water on a regular basis? How many glasses a day? _____

YES NO Do you have difficulties sleeping soundly through the night? _____

YES NO Do you feel fatigued on a regular basis?

YES NO Do you eat healthy? Briefly explain your diet _____

_____

HIGH MED LOW What is your level of stress? Explain_____

YES NO Have you been to a chiropractor before? If so, why and when? _____

_____

Physician: _____ Date: _____/_____/_____

Restoration Health & Chiropractic
365 E. Bailey Rd.
Naperville, IL 60565
(630) 506-7758

Presenting Problem

Patient Name_____ Date_____/_____/_____

What is the presenting problem/chief complaint? _____

When did the problem begin? _____

What was the mechanism/cause of injury? _____

Where is the pain located? _____
Describe the pain (ie burning, sharp, shooting, aching, boring, etc) _____
Rate the pain as it is right now, 0-10 with 0 being no pain and 10 being most excruciating pain. _____
Rate the pain when it's at its worst, 0-10 _____
Does anything alleviate the pain? _____
Does anything exacerbate the pain? _____
Does the pain radiate into the extremities? _____
Is the pain worse or better at any time of the day? If so, when? _____

Are there any other associated symptoms? _____

Does the pain affect any of your normal daily activities? What/How? _____

Have you sought any medical attention for this complaint yet? If so, who did you see and what was the therapy? _____

What kind of treatment have you sought for this problem? _____

Have you had any imaging for this problem (Xray, MRI, CT, etc.)? _____
Describe below any other problems you have been experiencing related or unrelated to the chief complaint

Office use only:
ICD9:

C	str/spr 847.0	seg dys 739.1	IVD syn 722.0	Cervico-cranial syn 723.2	cerv/brachial syn 723.3	brach rad/neur 723.4	Occipital Neur 723.8	
T	str/spr 847.1	seg dys 739.2	IVD syn 722.11	Intcost nuer 729.2/353.8	Backache Unspec 724.8	Thoracic Pain 724.1	TOS 353.0	
L	str/spr 847.2	seg dys 739.3	IVD syn 722.10	Lumbago 724.2	Sciatica 724.3	Facet syn 724.8	Polyalgia 729.9	
SI	str/spr 846.1	SI dys 739.4	Sacroilitis 720.2	PF 726.73	IT Band 728.89	Headache 784.0		

Severity: 1 2 3 Clinical Decision: Straightforward Low Moderate High

Physician: _____ Date: _____/_____/_____