OAK BROOK CHIROPRACTIC CENTER, P. C.

1000 Jorie Blvd., Suite 120 • Oak Brook, IL 60523

_______ / _______ / _______
Month Day Year

Acct. # _______________
Office Use Only

REQUIRED FOR YOUR CASE HISTORY FILE

Name ____

Address ____ Apt. ___________

City ________________________________ State _______ Zip ______________

Email Address ____

Phone # ______________________ Social Security # _________________________

Age ________ Birth Date ______________ Height _______ Weight _______ Blood pressure ____________

Sex _____M _____F Marital Status _____M _____S _____W _____D

Race ________________ Ethnicity ________________ Preferred Language ________________

Occupation ______________________ Employer ________________________ Years Employed ______

Employers Address ________________ City ____________ State_____ Zip_______ Work Phone # ________________

Spouse's Name ______________________ Occupation ___________________ Employer ____________________

Person Responsible for Account _______________________ REFERRED BY __________________________

Please fill in the blanks and circle the most accurate answers.

Are you a: Current Daily Smoker Current Sometime Smoker Former Smoker Never Smoker

Please list any allergies. ____

List any surgical operations and years. ____

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List medications you are currently taking with the approximate date started. ____________________________________

____

Are you (circle all that apply): in High School in College Working Disabled Exercising regularly Eating poorly Stressed

Using tobacco Abusing drugs Using alcohol Using caffeine Sexually Active

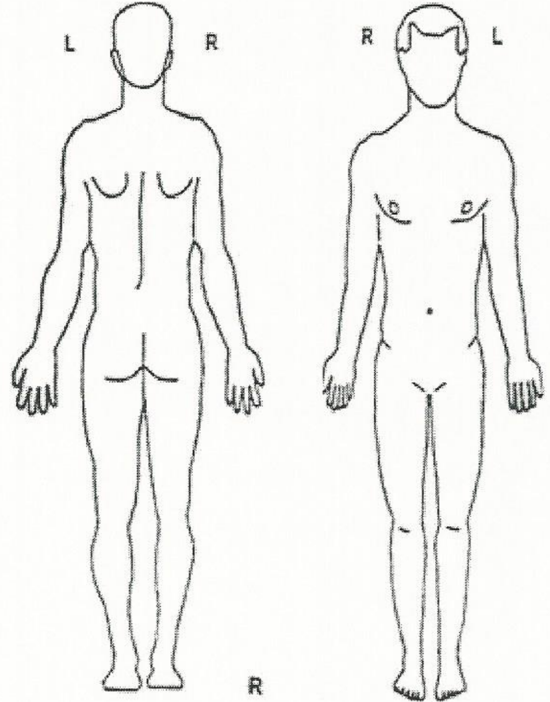
FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health.)

NAME	RELATION	HEALTH PROBLEMS

When did your condition start? _______________________

Please Mark Areas of Pain

Specifically describe what your problem is today and how it happened.



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Is your condition due to an accident or illness? _____________________

If an accident, did it occur at work? Yes No When ______________

Were you involved in an automobile accident? Yes No When __________

Is your pain located on the right, left, or both sides? Right Left Both

Is your condition changing? Better Worse No change

Have you had similar conditions in the past? Yes No

How often do you experience symptoms? 75-100% of the time 50%-75% of the time 25-50% of the time 0-25% of the time

Is your pain: Burning Numb Sharp Stabbing Tingling Achy Radiating Shooting Tight Throbbing

Please rate your pain on a scale of 0 to 10, 10 being the most unbearable. 0 1 2 3 4 5 6 7 8 9 10

Rate on a scale of 0 to 10 how your symptoms affect daily activities. 0 1 2 3 4 5 6 7 8 9 10

What makes your pain better? Acupuncture Ice Pain medications Stretching Chiropractic therapy Massage therapy

Physical therapy Therapy Heat Sleep/rest Nothing Other ___________________________

What makes your condition worse? ____

What do you hope to gain from treatment? (Circle all that apply) Become pain free Reduce symptoms Explanation of symptoms

Learn how to care for symptoms Resume normal activity

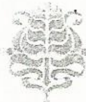
I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any feesfor professional services rendered me will be immediately due and payable. If you choose, a clinical summary of your visits can be provided within 3 business days. _________ initial

*** 24 HOUR NOTICE IS NECESSARY FOR CANCELATIONS OR YOU WILL BE CHARGED.** ________ initial

Patients signature: ______________________________________ Date _______________

Guardian or Spouse's signature authorizing care: ______________________________________ Date _______________

*If at any point this account goes to collection, you are responsible for any collection fees.



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Tel. (630) 990-7246
Fax (630) 990-7417

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and exercises on me, in a treatment room and in our gym (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the office listed above.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office 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, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

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

I agree to indemnify and hold harmless and defend Oak Brook Chiropractic Center, P.C. and it's employees from any and all claims resulting from injuries, including death, damages and losses sustained by me while using the gym. It is understood that in the event of injury or claim, it is the participant's responsibility to have health or other insurance.

Patient Signature____________________ Date________________

Witness Signature ___________________ Date ___________________