

ABOUT THE PATIENT

Innate Concepts Chiropractic, 668 E. Northwest Highway, Mount Prospect, IL 60056

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender M F
 Significant Other's Name _____ Kid's Names and Ages _____
 Your Employer _____ Type of Work _____
 e-Mail Address _____ Have you been to a chiropractor before? No Yes
 Emergency Contact _____ ph # _____
 Name of Medical Doctor(s) _____ How did you hear about us? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Innate Concepts Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

Patient / Parent Signature _____ (This represents a long term authorization for all occasions of service) _____ Date _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

2. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

3. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

4. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better? _____

7. What makes it worse? _____

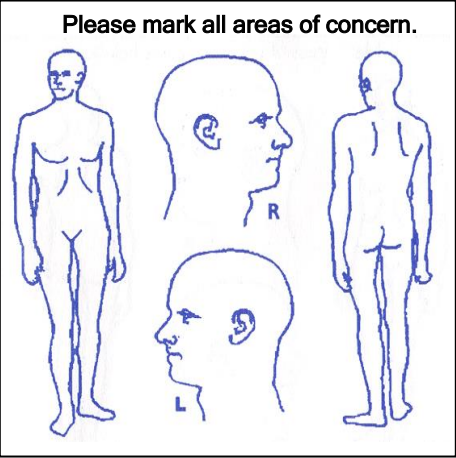
8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

10. Results: _____

NOTES: _____

Are you pregnant?
 Yes No



GENERAL HEALTH HISTORY

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Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- Headaches
- Ear Infections
- Colic
- Allergies / Asthma
- Medication Side Effects
- Recurring Fevers
- Digestive problems
- Bed Wetting
- Chronic Colds/Sinus
- Other _____

Past Present

- Vision Problems
- Sleeping Problems
- Growing Pains
- Dental Problems
- Temper Tantrums
- ADHD
- Seizures
- Scoliosis
- Ever Needed Stitches

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 mo. _____ Total during lifetime _____
3. Name of Pediatrician and Other Doctors: _____
4. Date of Last Visit ____ / ____ / ____ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: Hospital Birthing Center Home
7. Complications During Pregnancy: No Yes Explain: _____
8. Ultrasounds During Pregnancy: No Yes How Many: _____
9. Medication During Pregnancy / Delivery No Yes List: _____
10. Cigarette / Alcohol Use during Pregnancy: No Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ": No Yes, Name _____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries: _____
15. Please describe any past conditions and treatment received: _____

16. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

- Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____
- Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____
- Is there any other family history you want us to know? _____

Innate Concepts Chiropractic

Paying for your care is easy here!

Mark which one works best for you:

<p>_____ No Insurance: Easy! Our Care Plans and simple payment arrangements have helped over 5,000 people and will work great for you too!</p>
<p>_____ Health Insurance: These days, insurance pays very little for natural, drugless care to get you healthy. So we make it easy!</p> <ul style="list-style-type: none">• We will verify any benefits you may have and send your claims in to your insurance for you.• If they pay anything after your deductible is met, we will accept payments directly from them.• You are responsible for any deductible, co-insurance, co-pays and unpaid visits.• Of course you can use your HSA, HRA, and Flex dollars here!• For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.
<p>_____ Auto Injury: Auto related injuries are typically covered at 100% in our state. Even if you were at fault or were a passenger. In the event the claims are denied, we will bill your medical insurance. All we need is your:</p> <ul style="list-style-type: none">• Claim number• Insurance Information• Attorney Information
<p>_____ Work Injury: Work injuries are covered 100% for up to 12 weeks of care. All we need is your:</p> <ul style="list-style-type: none">• Claim number• Insurance Information• Attorney Information
<p>_____ Medicare: Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations. After this, you will receive a significant Medicare discount (\$35/visit).</p> <ul style="list-style-type: none">• We simply need a copy of your Medicare card.• Medicare supplements normally don't pay anything.• If you do not have a secondary insurance, you will be responsible for your 20%.

For Your Convenience:

We like to make things as easy as possible for our patients – including paying for care! Prior to beginning treatment, we will go over all costs anticipated with your customized plan. Feel comfortable knowing we use a secure portal to hold your credit card information and only process payments if:

- You give us authorization.
OR
- Your balance goes unpaid for 30 days. At that time, we will run the card on file for the outstanding balance on your account.

Print Name _____

Date _____

Sign Name _____

OFFICE POLICY

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SPINAL CHECK-UP:

We recommend **everyone** have their spine checked early for spinal problems. Especially **children** to see if their spine is developing abnormally. Prevention is the best medicine. A spinal check-up is easy and fun for kids.

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule.
- Feel welcome to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care ends early.
- **I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.**
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. He is here to help you any way he can. We want you to do great! 😊

OFFICE VISITS MAY INCLUDE:

- **Specific Chiropractic Adjustments** to promote mobility, stimulate tissue, enhance alignment. This is when the Doctor works directly on your neck or back, sometimes making a popping sound. \$45-65
- **Extremity Adjustments** to promote mobility, stimulate tissue, enhance alignment of extremity joints. \$35
- **Intersegmental / Mechanical traction** to tense / relax soft tissues, aid healing and mobility. This is the black table with the rollers that effectively extend, stretch, and traction the spine. \$30
- **Heat** for sub-acute or chronic conditions. The digital heat pack used on the area of concern. \$10
- **Cold** to reduce swelling, this is the ice pack used on the area of concern. \$10
- **Electric Muscle Stim.** To control swelling, modulate pain, tone muscles. \$30
- **Manual Therapy / Manual Traction** to modulate pain, increase flexibility, reduce swelling, mobilize soft tissues. This is hands-on work to your spine or other joints, performed by the Doctor. \$35
- **Therapeutic Exercises** to improve spinal flexibility, strength and motion. These are stretches or exercises that you perform or the Doctor administers to you. Excellent for the neck, mid, and lower back. \$35 per unit
- **Neuro Muscular Re-Education** to develop and improve coordination and balance, as well as promote flexibility and strength. An example is the Wobble chair the Doctor has you exercise with. \$35 per unit
- **Myofascial release (Massage)**, muscle work to reduce muscular adhesions and aid healing. This is commonly called 'Massage' or "Trigger point Therapy" and can be performed in sessions of 15 to 90 minutes. \$22.50 per unit
- **Supports/Pillow/Braces** if needed and as priced.

Massage Therapy Policy:

- Please arrive 5-10 minutes before your scheduled time. (You are not guaranteed the full amount of time if you show up late).
- We request a 2-hour cancellation notice. If you no call/no show you will be responsible to pay in full for the massage.
- A card must be provided over the phone when booking your appointment to hold your spot. Payment is due at time of service. If you have a gift certificate or massage promotion it must be presented before your massage to accept validation.
- We shall not be held liable for any conditions that arise after the massage. Patients agree to this for the initial and future massages by signing the informed consent form. Consent may be withdrawn at any time by either party and patients are encouraged to continuously communicate boundary requirements with us. The patient agrees to state all information on the health history form accurately and completely, and will inform the therapist of any new conditions or changes in health.

***We will maintain patient confidentiality of all patient information except in the event the patient agrees to disclosure in writing or by court order.**

Print Name: _____

Date: _____

Patient/Legal Guardian Signature: _____

Staff Initial: _____