Dr. Gus Advanced Health and Wellness Centers

Applied Wellness Center
13301 S. Ridgeland Ave., Suite A
Palos Heights IL 60463
(708) 489-3700

Bolingbrook Wellness Center
550 E. Boughton Rd. Suite 205
Bolingbrook, IL 60440
(630) 410-2620

PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms. ____
Last Legal First Middle Initial

Name you prefer to be called (nickname):________________________ Social Security #: ________________________

Phone #: ________________________ Cell #:_____________________________

E-mail: ____ Driver's License #: ______________________________

Address:____ City: ___________________State: _______Zip:__________

Age:______ Birth Date:______________ Sex:_________ Patient's Employer:___________________________________

Work Address: ___________________________________ City:__________________ State:________ Zip:___________

Phone #: ___________________Ext:_________ Occupation: _________________________________

Please circle: Single/Married/Divorced/other:_________________Spouse/partner's name: _________________________

Note: *Fill out this section only if insured is different than patient.* Name of insured:_______________________________

Relationship to insured: (please circle one): Spouse/Child/Other: ____

Address:____ City:__________________ State:________ Zip:___________

Social Security #:_________________________ Phone #: ____________________Birth Date:____________________

Insured's Employer (if different from patient): ______________________________ Phone #: ______________________

Work Address:___________________________________ City:__________________ State: ________ Zip:__________

PERSONAL HEALTH HISTORY

Have you been to our clinics for anything before? No/Yes, explain:____

Have you ever been to chiropractor before? No/Yes, what for? ____

Who referred you to our practice? Person:___________________________ Advertisement:________________________

Are you, or might you be pregnant? No/Yes Do you have a pacemaker? No/Yes

What do you hope to do better or enjoy more when you regain your health? ____________________________________

____

____

When was your last physical exam? ___________________Results:____

Date, and results, if known, of any recent tests: cholesterol:__________________ other:_________________________

Please list all current medications, vitamin/mineral supplements, herbs, including dosage: _________________________

____

____

List any known allergies: ____

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If you smoke or have ever smoked, describe how much, and for how long:_______________________________________

Describe your recreational drug use:_________________ typical alcohol intake (#of drinks per day/per week): _________
Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.):__________________________

____

____

Please list and describe all significant previous surgeries: ____

____

____

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:________

____

____

Have you traveled outside of the U.S. within the last two years? If so, where: ____________________________________

CHIEF COMPLAINT

Name: ______________________________________**Date:**______________

1. Are your present symptoms or conditions related to, or the result of an auto accident, work-related injury, or other personal injury *someone else might be legally liable for*? Yes**/**No **Please Initial:**________ If yes, please fill out accident-specific form at the front desk

2. Please describe the nature of your condition at this time: ____

____

____

3. When did your condition first begin? Year:__________Month:___________Day/Date:___________Time:

4. Cause of condition (circle all that apply): auto accident, work injury, Sudden trauma, Re-occurrence, Repetitive trauma, gradual onset, athletic activity, unknown, Other explain:____

5. Have you had anything like this before? Yes/No: when?: ____

6. How often does the problem re-occur?: ____

7. Is the pain usually (circle) On/Off or constant Usually lasting: ___minutes ___hours ___days ___weeks other:____

8. Lately, has the pain been(circle): Getting Worse, Better, Same, On&Off, Constant

9. Does the pain radiate?, to where: ____

10. What makes it feel better? ____

11. What makes it feel worse? ____

12. If you have seen another professional for this problem, or done any self-care, describe the type of treatment *and* results:____

____

____

13. At what time of day, week, or setting (home, recreation, work) is your pain worst?__________________________

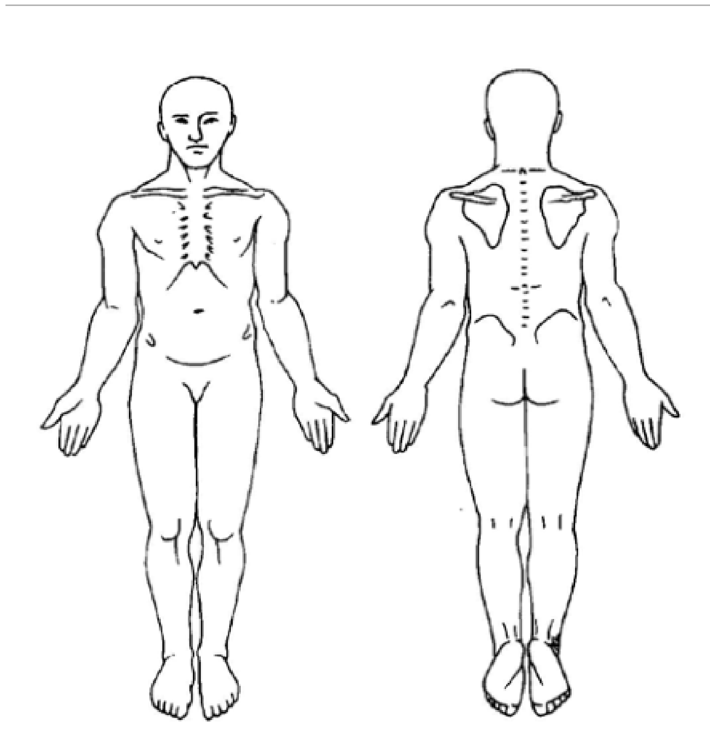
14. Please list any activities you are unable to perform/have not performed due to the pain, or for fear of making the pain worse? ____

15. What else would you like the Dr. to know about you and/or your condition: ________________________________

____

PLEASE MARK THE AREA(S) ON THE DIAGRAM WITH THE APPROPRIATE SYMBOL(S) FOR THE SENSATION(S) YOU FEEL:

ACHING: == SHARP/STABBING: // PINS & NEEDLES: 00 NUMBNESS: ++ BURNING: xx



PLEASE MARK YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10
Pain Currently

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10
Pain At Its Worst

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10
Pain Typically

FAMILY HISTORY

Please list any significant health problems of parents, grandparents, or siblings:________________________________

____

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NUTRITION

Height: __________ Present Weight: ___________ Weight one year ago:__________ Preferred Weight:___________

Please indicate which you eat on a typical day: _______ Breakfast _______Lunch ________Dinner # of snacks/day:______

Please indicate the estimated number of servings of each of the following, which you eat on a typical day:

_____ Eggs _____ Red Meat _____ Fruits *Fats/Oils:*

_____ Cheese _____ Pork _____ Vegetables _____ Canola _____ Corn

_____ Skim Milk _____ Fish _____ Desserts _____ Olive _____ Peanut

_____ 1% Milk _____ Ham _____ Grains,Rice,Pasta,Cereal,Bread _____ Safflower _____ Sunflower

____ 2%Milk _____ Beans _____ Butter _____ Other: ________________

_____ Whole Milk_____ Chicken/Turkey _____ Margarine _____ Other: ___________

_____ Yogurt _____ Tofu/Soy _____ Nuts/Seeds/Peanut Butter _____ Bacon/Hot Dogs, etc.

_____ Other: __________ _____ Sausage/Lunch Meats _____ Other: ____________ _____ Spicy Foods

Please indicate the estimated # of servings (6-8 oz. cups) of each of the following, which you drink on a typical day:

______Caffeinated Coffee ______Regular Soft Drinks _______Water ______Other: ___________

______Decaffeinated Coffee ______Diet Soft Drinks _______ Fruit Juices ______Other: ___________

______Regular Tea _______Herbal Tea _______Sports Drinks (i.e., Gatorade) ____Other: ____

On a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet: ________________________________

If you try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe:

____

Was your special diet prescribed by a physician or nutritionist? (circle one) Yes / No

Do you have success in following your special diet? (circle one) Yes / No explain:__________________________________

____

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REVIEW OF SYSTEMS

Please write a **number** in the spaces below**: 1.** presently have **2.** previously had **3.** related to accident

GENERAL

- ______Frequent or recurring Chills
- ______Epilepsy/Convulsions/Seizure
- ______Frequent or recurring Dizziness
- ______Frequent or recurring Fainting
- ______Frequent or recurring Fatigue
- ______Frequent or recurring Fever
- ______Headache
- ______Frequent or recurring Sleep loss
- ______Recent Weight Change
- ______Anxiety/Panic Attacks
- ______Depression
- ______Frequent or recurring Sweats
- ______Frequent/recurring hives/rashes
- ______Frequent/recurring colds/flu
- ______Vertigo
- ______Fainting
- ______Fears/Phobias

GENITO-URINARY/ENDOCRINE

- ______Bedwetting
- ______Frequent urination
- ______Urinary tract infections
- ______Painful urination
- ______Painful menstruation
- ______Prostate trouble
- ______Loss of bowel/bladder control
- ______Gall Stones
- ______Blood in urine
- ______Thyroid problems/Goiter
- ______Kidney stones
- ______Irregular menstrual cycle
- ______Hot flashes
- ______Diabetes
- ______Pelvic Inflam. Dis.
- ______ Infertility/Miscarriage

RESPIRATORY

- ______Spitting up phlegm
- ______Chest pain
- ______Spitting up blood
- ______Difficult breathing
- ______Asthma
- ______Wheezing
- ______Chronic cough
- ______Allergies

______GASTROINTESTINAL

- ______Bloating, belching, gas
- ______Esophageal reflux
- ______Constipation
- ______Frequent heartburn
- ______Ulcer
- ______Digestive Problems
- ______Parasites
- ______Cold Hands &/or Feet
- ______Pain over stomach
- ______ Diarrhea
- ______Vomiting
- ______Nausea
- ______Poor appetite
- ______Candida/Yeast
- ______Hernia

______CARDIOVASCULAR

- ______Hardening of arteries
- ______High blood pressure
- ______Pain over heart
- ______Bad circulation/ankle swell
- ______Rapid heart beat
- ______Heart Disease
- ______Palpitation / Irreg hear beat

EYES, EARS, NOSE, THROAT

- ______Frequent/recurring sore throat
- ______Deafness
- ______Dental problems
- ______Ear problems/Infections
- ______Sinus problems
- ______Frequent/recurring nose bleeds
- ______Vision problems
- ______Canker sores
- ______Cold sores

MUSCULOSKELETAL – pain, numbness, weakness in:

- ______Low Back
- ______Neck
- ______Upper Back
- ______Mid Back
- ______Between Shoulder Blades
- ______Shoulder Blade: R/L both
- ______Shoulder: R/L both
- ______Foot: R/L bunions/corns
- ______Fibromyalgia
- ______Arm: R/L both
- ______Elbow: R/L both
- ______Hand: R/L both
- ______Leg: R/L both
- ______Hip: R/L both
- ______Knee: R/L both
- ______Ankle: R/L both
- ______Spinal curvature
- ______Arthritis/Gout

OTHER

- ______Abscesses
- ______Acne
- ______Alcohol/Drug Addiction
- ______Anemia
- ______Athlete's Foot/Fungal
- ______Cancer
- ______Chicken Pox
- ______Eczema
- ______Genital Warts
- ______Warts
- ______Hepatitis
- ______Scarlet Fever
- ______HIV
- ______Chicken Pox

OTHER

- ______Mononucleosis
- ______Psoriasis
- ______Sexually Transmitted Disease
- ______Whooping Cough
- ______Ingrown Toenails/Hang-nails
- ______Dry/Cracked heels

OTHER

- ______Genital Herpes
- ______Pneumonia
- ______Sexual Abuse
- ______Worms
- ______Teeth Problems/Cavities

OTHER

- ______Mumps
- ______Root Canal/gum disease
- ______Stroke
- ______Shingles
- ______Penile/Vaginal Discharge

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FINANCIAL POLICY

Patient Name: ____**Social Security #:**________________________
Last Legal First Middle Initial

Name of Insured: ____ Social Security #.__________________________
(if different from patient) Last Legal First Middle Initial

Primary Insurance Company or Health Care Plan Name: _____________________ **Effective Date:**_____________

ID#: __________________________________ **Policy/Group#:** ____

Secondary Insurance Company or Health Care Plan Name: ___________________Effective Date:__________________

ID#:_________________________________ Policy/Group#: ____

AUTHORIZATION (to release information & settle insurance appeals or disputes)

I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE OF PATIENT/GUARDIAN: ____**DATE:**______________

ASSIGNMENT (of benefits to doctor)

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Applied Wellness Center, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. Applied Wellness Center may use my health care information and may disclose such information to the my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE OF PATIENT/GUARDIAN:____ **DATE:** ______________

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

SIGNATURE OF PATIENT/GUARDIAN:____ DATE:________________

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or person under my care by Applied Wellness Center. I have had an opportunity to discuss with Applied Wellness Center staff, or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care my involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to relay on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.
I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonable undetectable by the doctor.
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, acknowledge my understanding of its contents.

SIGNATURE OF PATIENT/GUARDIAN:____ DATE:________________

WE May SUBMIT AN INITIAL REPORT TO YOUR PRIMARY CARE DOCTOR. PLEASE PROVIDE US WITH THE NECESSARY INFORMATION:

Primary care Dr:___________________________________ **Tel**:_______________ **Address**:____________________

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATION

____________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
- **a.** Telephoning my home phone, cell phone, and or work phone and leaving a message on my answering machine or with the individual answering the phone;
- **b.** Email at the email(s) provided in my intake form.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

SIGNATURE OF PATIENT/GUARDIAN:____ **DATE:** __________________