New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

Patient Name **Date**

General Information

Address City State

Home Phone Occupation Zip

Work Phone SS# Date of Birth

Mobile Phone E-mail Receive email communications? ☐ Yes ☐ No

Emergency Contact Relationship Phone

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No Family Physician Phone

What was your experience? ☐ Very good ☐ Good ☐ No change ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for?

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for?

Insurance Information

Insurance Company Phone Date Called

ID # Co-Pay $ Covered %

Visit # Deductible Amount

Contact Name Referral ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities?

☐ Work ☐ Sleep ☐ Walking ☐ Sitting
☐ Standing ☐ Emotional ☐ Relationships ☐ Social Life
☐ Sexually ☐ Recreation ☐ Bending ☐ Stretching
☐ Other

What have you done about this?

Are you interested in:

☐ Pain Relief ☐ Preventative Care ☐ Oriental Nutrition
☐ Holistic Health ☐ Stretching/Yoga ☐ Maintenance Care
☐ Stress Relief ☐ Herbal Therapy
☐ Other

What are your health goals?

List any past or future surgeries:

List any significant trauma & when it occurred
(e.g. auto accident, falls, emotional, sexual, etc.):

List exercise and sport activities you
have been or are currently involved in:

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what? _____

Do you take medication? ☐ Yes ☐ No If so, what types and how often? _____

Do you take supplements? ☐ Yes ☐ No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ High/low blood pressure	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? _____ Do you have a low point during the day? ☐ Yes ☐ No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

Female Concerns

Date of last menstruation _____ Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long? _____

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge

Other _____

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other _____

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of _____	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other: _____
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	_____
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	_____
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	_____

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

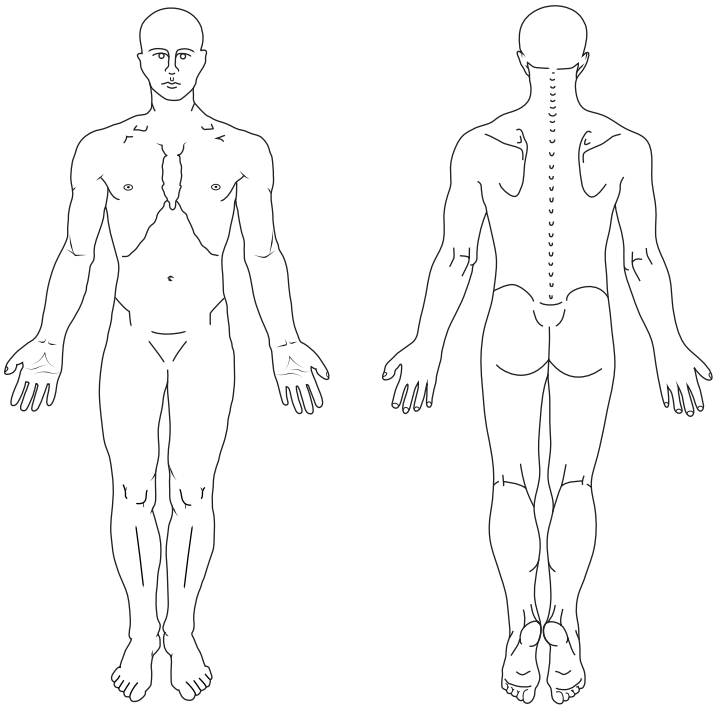
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

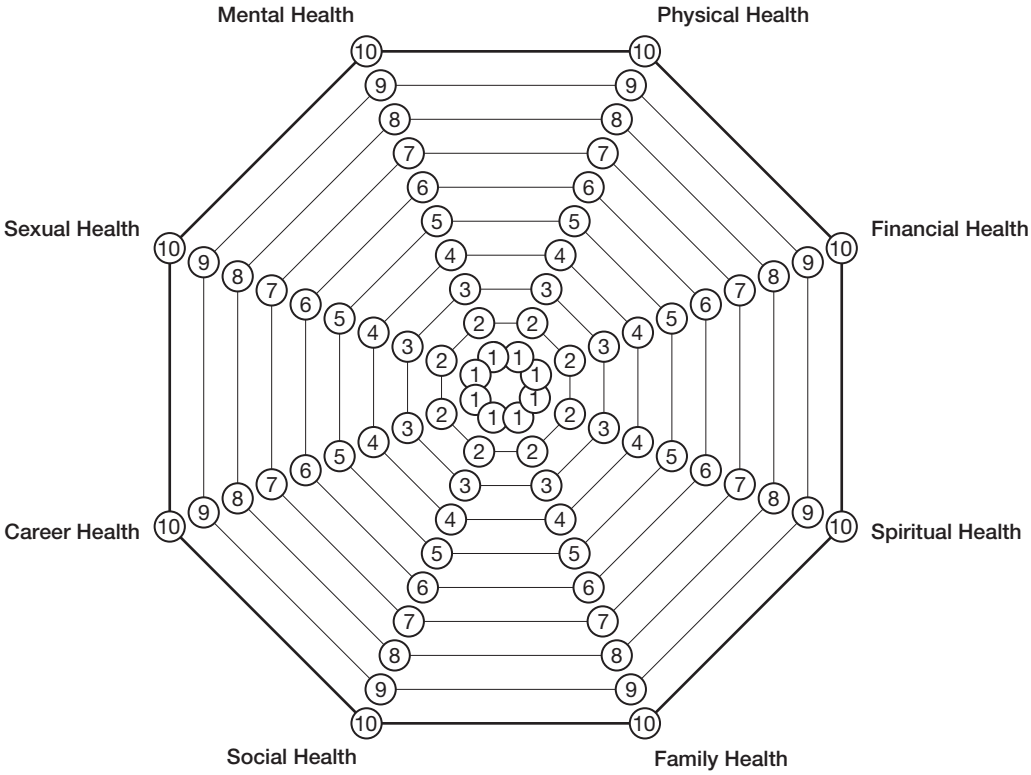
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	X X X X	/ / / /

Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____

York Chiropractic Clinic Registration and History

PATIENT INFORMATION

Date _____

First Name_____

Last Name _____

Address _____

City_____

State _____ Zip Code _____

Sex ☐ Male ☐ Female

Date of Birth: _____

Home Phone (_____) _____

Cell Phone (_____) _____

Best place to reach you and time _____

Email _____

Do you wish to receive e-mails with health tips and promotional deals? ☐ Yes ☐ No

IN CASE OF EMERGENCY, CONTACT

Name _____

Home Phone (_____) _____

Relationship _____

Patient Employer/ School _____

Employer/ School Phone (_____) _____

Spouse's Name _____

Birthdate_____

Spouse's Employer_____

Whom may we thank for your referral? _____

INSURANCE INFORMATION

Who is responsible for this account _____

Relationship to patient _____

Insurance Co._____

Is patient covered by additional insurance

☐ Yes ☐ No

Subscribers name_____

Birthdate_____

PATIENT CONDTION

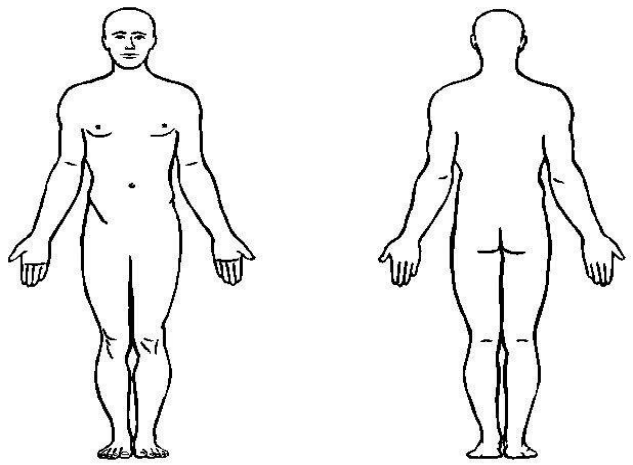
Reason for Visit?_____

When did your symptoms appear?_____

Is this condition getting progressively worse?

☐ Yes ☐ No

Mark an X on the picture where you continue to pain, numbness, or tingling



Rate the severity of the pain on a scale from 1(least pain) to 10 (serve pain) _____

Type of Pain:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness

☐ Aching ☐ Shooting ☐ Burning ☐ tingling

☐ Cramps ☐ Stiffness ☐ Swelling

☐ Other _____

How often do you have this pain?

_____

Is it constant or does it come and go?

_____

Does it interfere with your

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movement that are painful to perform

☐ Sitting ☐ Standing ☐ Walking ☐ Bending

☐ Lying Down

Health History

What Treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Allergy shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Sexually Transmitted Diseases ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid Problem ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Bleeding disorder ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Tumors ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Chemical dependency ☐ Yes ☐ No	Kidney Disease Yes ☐ No	☐ Prosthesis Yes ☐ No ☐	Other _____
Chicken Pox ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	_____

Exercise	**Work Activity**	**Habits**	
☐ None	☐ Siting	☐ Smoking	Packs/ Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/ Caffeine Drinks	Cups/Day_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason_____

Are you Pregnant ☐ Yes ☐ No Due Date_____

Injuries/ Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Dislocations		
Surgeries		

Medications	**Allergies**	**Vitamins/ Herbs/ Mineral**

York Chiropractic Clinic

Dr. Noelle O`Connor D.C 486 Spring Road Elmhurst, IL 60126 | 630-834-8536 Fax: 630-834-8544 | info@yorkchiropractic.net

Auto Accident Report Form

Name:_____ Time of Incident:_____ □ a.m □ p.m

Date of Accident: _____City of Accident:_____

Street of Accident: _____Cross Street (Intersection): _____

Road conditions at the time of the incident: □ Wet □ Dry □ Icy □ Other _____

Did the police come to the scene of the accident? □ Yes □ No

Was an accident report filed? □ Yes □ No

Were you taken to a hospital? □ Yes □ No

Hospital Name & City: _____

How did you get to the hospital? _____

Were X-Rays taken? □ Yes □ No

If yes, what was X-Rayed? □ Head □ Neck □ Upper Back □ Mid-Back □ Lower Back

If auto accident, you were the □Driver □ Passenger □ Pedestrian

If auto Collison you were struck from □Behind □ Right Side □ Left side □ Front □ Auto was parked

Did your car strike the other(s) involved? □ Yes □ No Did the other car strike yours? □ Yes □ No

List the extent of injuries as you know them

Head:_____
Chest:_____
R/L Shouder:_____
R/L Arm:_____
R/L Hip:_____
R/L Leg:_____
R/L Knee:_____

Other:_____

CHECK SYMPTONS YOU HAVE NOTICED SINCE ACCIDENT:

□ Headache	□ Irritability	□ Numbness in Toes	□ Face Flushed	□ Feet Cold
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Buzzing in Ears	□ Hands Cold
□ Neck Stiff	□ Dizziness	□ Fatigue	□ Loss of Balance	□ Fever
□ Nervousness	□ Cold Sweats	□ Upset Stomach	□Loss of Taste	□ Diarrhea
□ Sleeping Problems	□ Head Seems too Heavy	□ Depression	□ Fainting/ Light Headed	□ Constipation
□ Back Pain	□ Pin & Needles in Legs	□ Pins & Needles in Fingers		□ Loss of smell
□ Loss of Memory	□ Lights bothers eyes	□ Earrings ring		

□ Other_____

Have you lost any days of work? □ Yes □ No Dates_____

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Personal Injury Form

My Insurance Company or Law Firm Name

_____

Person responsible for injuries Insurance Company or Law Firm Name

_____

Have you been contacted by an insurance adjuster or company representative regarding the claim? □ Yes □ No

Claim or Case Number:_____

Adjustor or Lawyer Name:_____

Phone Number:_____

Fax Number: _____

Do you have an attorney that has advised you in this case? □ Yes □ No

Atty Name: _____

Address: _____Phone Number:_____

Fax:_____

NOTICE: Having insurance information is not a guarantee that they will cover your fees in full. Whatever your insurance provider does not pay will be your responsibility. If you fail to keep in contact with the insurance company and your case closes before our bill is paid in full, you will be responsible for your balance.

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Office & Financial Policies

1. **Know your own Insurance Plan Benefits**
   a. As **a courtesy to you**, our office verifies information prior to your visit whenever possible
   b. Be aware the insurance company states the **"the quote of benefits given is not a guarantee of payment."**
   c. **We cannot be held responsible** for any misinformation we are given by your insurance.
   d. It is ultimately your responsibility to know your own benefits and to pay the balances as indicated by your insurance company.
2. **Insurance Claim Filing and Payment**
   a. **Our office files your insurance claims as a courtesy.**
   b. If payment from an insurance company is withheld for **any reason**, payment in full will be expected from the insured within 21 days of the first statement and/or 60 days of the service date.
   c. **Assignment is accepted on Medicare Part B Claims.**
   This means that Medicare participants are responsible for:
   - Your $150 deductible.
   - The balance of the 20% co-insurance after Medicare pays 80% of their allowed amount.
   - Any non-covered services (Medicare doesn`t cover any exams, therapy or massage in a chiropractic office)
3. **Account Balances**
   a. **Co-payments, previously determined non-covered services or services rendered to a non-insured patient are expected at the time services are rendered**.
   b. We accept Visa, MasterCard, Cash or local check. **A fee of $35.00 will be assessed for any returned checks.**
   c. **For those patients with deductibles of $200 or more,** we ask for a down payment toward your expected balance.
   d. **Statements are generally mailed from our office on a monthly basis and payment is expected upon receipt**. Your account will be considered PAST DUE after 21 days of the first statement and/or 45 days of the service date and DELINQUENT after 60 days.
   e. **Patient account balances that are 90 days past due from the date of service will automatically** be forwarded to our collections agency.

Missed Appointment Policy

We value your time and we want your chiropractic experience to be positive and helpful in all ways. Chiropractic and massage are most effective when kept consistently. It is our pledge to meet with you for your appointment in as timely a manner as is possible and we expect for you to make all reasonable efforts to attend your appointment and to be on time.

Cancellation of an Appointment:

When you schedule your appointment, you have reserved this time in our schedule and we have placed it aside to meet with you. If you must cancel or change your appointment, we require that you contact our office at 1-630-834-8536 **at least an hour in advance.**

Late Cancellations and No show Policy:

York Chiropractic Clinic will charge for each appointment that is missed without adequate notice ("no show".) A no show is an appointment that is:

- Missed without notice
- Missed with less than an hour notice
- Missed due to arriving 15 minutes or more beyond the scheduled appointment time.

If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limits, you will be charge a fee of $30 dollars. The only exception to this policy are appointments missed due to the last minute illness or emergencies.

You will be billed directly for missed appointments. Payment for missed appointments is due on or before your next scheduled appointment. If you have not paid in advance, you should be prepared to pay the outstanding balance at the time you check in for your next appointment.

Thank you for taking time to review our missed appointment policies. We hope making these policies clear will eliminate any possible misunderstanding. By signing below, you are indicating that you have read, understood and agree to these conditions.

Patient Signature: _____ Date: _____

York Chiropractic

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN'T GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act give you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** is providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a consultation or physical examination.
- **Payment** is such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects such as an internal review.

We may contact you to provide appointment reminders, information about treatment alternatives or results of test taken.

Any other users and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, expect to the extent that we have already taken actions relying on your authorizations.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or locations. An example such as a different mailing address for statements or a different telephone number for communication.
- The right to inspect and copy your protected health information. The practice charges reasonable fees based on Illinois laws. If the requestor agrees to pay the fee in advance, the records will be provided. Otherwise, the records will not be provided, unless the Privacy Officer determines that the charge is burdensome to the requestor. The charges cannot exceed the following: $23.78 handling fee plus 0.89 cents each for pages 1-25, 0.59 cents each for pages 26-50, and 0.30 cents each for pages 51 to end.
- The right to amend your protected health information. The practice documents all requests, responds to all requests in a timely fashion, and informs requestor of denial in whole or in part.
- The right to receive an accounting of disclosures of protected health information. The practice allows an individual to request one accounting within a 12- month period free of charge. The practice charges a reasonable fee for more frequent account requests. The charge will be determined at the time of the request.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2014 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

The practice never requires an individual to waive any of his or hers individual rights as a condition for the provision of treatment, except under very limited circumstances allowed under law.

You have the right to file a written complaint with our office, Attn: Privacy Officer, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of this office. We will not retaliate against you in filing the complaint.

Privacy Officer: Angela Fiore

Email: info@yorkchiropractic.net

Phone Number: 630-834-8536

Address: 486 Spring Road

Fax: 630-834-8544

Elmhurst, IL 60126

Signature of Patient OR Legal Guardian (if patient is a minor) **Date**