PATIENT PERSONAL/CONFIDENTIAL DATA

No._____
Patient:_____
Address:_____
City:_____
State_____
Zip_____
Email Address: _____

Date:_____
Date of Birth:_____
Social Security No._____
Home Phone:_____
Cell Phone:_____
Work Phone:_____

How did you hear of this clinic?_____

PATIENT HEALTH QUESTIONNAIRE

Describe your current complaints (Begin with what bothers you the most)_____

_____

_____

When did the symptoms begin? _____

What caused these symptoms? _____

_____

Describe your symptoms (Circle): Sharp Dull Ache Numb Burning Tingling
Other: _____

Do your symptoms radiate? If so, Where? _____

What is the severity of your symptoms? 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms (Circle One): Coming & Going Frequent Constant

If your symptoms come and go or are frequent, how long do they last?_____

Are your symptoms (Circle One): Getting Better Not Changing Getting Worse

What activities make your symptoms WORSE? (Circle all that apply)

Sitting Standing Laying Walking Running Sleeping School

Work Driving House Work Golf Yard Work Exercise Bending
Other: _____

What makes your symptoms BETTER? (Circle all that apply)

Sitting Standing Laying Walking Sleeping Bending Rest

Ice Heat Drugs Massage Physical Therapy
Other: _____

What else have you tried to ease your symptoms that did not hurt nor help?_____

_____

Who else have you seen for your current symptoms? (Circle all that apply)

NO ONE Medical Doctor Other Chiropractor Physical Therapist Other:_____

What tests have been performed for your symptoms? X-Rays date_____

MRI date_____ CT Scan date_____ Other date_____

Have you had similar symptoms in the past? YES NO

If yes, Describe what and when:_____

If yes, Who did you see and did it help?_____

What is you Occupation?_____

Are your symptoms affecting your work? YES NO

HOW?_____

How would you describe your exercise? None Light Moderate Strenuous

How would you describe your diet? Poor Average Healthy

How would you describe your stress? None Light Moderate Very Stressed

List all surgeries and hospitalizations with dates:_____

_____

_____

List ALL medications and supplements:_____

_____

_____

List any other traumas including vehicle accidents, work accidents, sports injuries with dates:_____

_____

_____

Has an IMMEDIATE family member had any of the following: (Circle all that Apply)

Rheumatoid Arthritis Heart Disease Diabetes Cancer Lupus

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Physician Signature:_____ Date:_____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

_Spinal manipulative therapy
_Range of motion testing
_Muscle strength testing
_Laser light therapy
_Radiographic studies
_Other (please explain)
_Acupressure/ Accustim
_Vital signs
_EMS
_Palpation
_Orthopedic testing
_Postural analysis
_Traction
_Physical therapy/exercises
_Stretching
_Manual muscle therapy
_Basic neurological testing

The material risks inherent in Chiropractic Adjustment.

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the history part of your examination and X-ray. Stroke has been subject of tremendous disagreement. The incidences of stroke are exceedingly rare and estimated to occur between one in one million and one in five million cervical adjustments. The other complications are generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

_Self-administered, over-the-counter analgesics and rest

_Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers

_Hospitalization

_Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it if postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Ethen and have had my questions answered to my satisfaction. By signing below I stated that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I herby give my consent for treatment.

Patient Name: _____ **Date:** _____

_____ _____

Patient Signature **Signature of Parent or Guardian**

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized be paid directly to this chiropractor office will be credited to my account upon receipt. However, I clearly understand that all services rendered to me 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 fees for professional service rendered to me will be immediately due and payable.

Patient Name: _____ **Date:** _____

_____ _____

Patient Signature: **Signature of Parent or Guardian**

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patients) any person or cooperation which is or may be liable under to the clinic or to the patient for all or part of the clinic's charge, including, but not limited to hospital or medical service companies, workers compensation, welfare funds, the patient's employer.

Patient Name: _____ **Date:** _____

_____ _____

Patient Signature **Signature of Parent or Guardian**

_____ _____

Physician Signature **Date**

Ethen Chiropractic & Wellness, S.C.
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Joseph Ethen DC, MS, ATC
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Glencoe, IL 60022
847-835-4700
Fax: 847-835-8408

PRACTICE REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 02/13/06.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____
Patient
Date_____