CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Lincolnwood Chiropractic Health Center
6837 N Lincoln Ave
Lincolnwood, IL 60712
Tel: 847-675-8305
Fax: 847-675-8306

Your First Name _____ Your Last Name _____ Gender ☐ Male ☐ Female _____ Birth Date MM/DD/YYYY

Street Address _____ City, State _____ Zip Code _____ Telephone Number(s) _____

If you were referred, whom can we thank? _____ Email Address _____ Preferred method of contact: ☐ Telephone ☐ Email ☐ Text

Marital Status: ☐ Single ☐ Married Do you have children: ☐ Yes ☐ No If yes, ages: _____

Spouse's Name

Occupation/Employer ☐ Retired _____ Emergency Contact _____ Phone Number _____ Relationship

Primary Care Physician's Name _____ City, State _____ Primary Hospital/Medical Facility _____

Have you ever been treated by a Chiropractor before: ☐ No ☐ Yes If yes, with whom/where? _____

The doctor and staff at Lincolnwood Chiropractic Health Center understand that our primary purpose is to provide you with the highest quality of care. We pledge to do this, and to do our part in controlling medical costs.

FINANCIAL POLICY

Your insurance policy is a contract between you and your insurance company. Patients are encouraged to contact their plans for clarification of Chiropractic benefits prior to services being rendered. You are ultimately responsible for any out-of-pocket obligations: copays, co-insurance, or deductibles determined by your insurance plan.

Non-Covered Service* fees are due at the time of each visit. (Medicare/supplemental coverage is limited to a spinal adjustment. Any other service rendered by the Chiropractor, such as an examination and evaluation or other therapies are considered non-covered services under Medicare when rendered by a Chiropractor.)

Delinquent or past due account balances over 90 days are subject to collection proceedings. We reserve the right to refuse to see any patient with a delinquent account.

If you miss a scheduled appointment without cancelling or rescheduling within 24 hours in advance you may be charged with a fee. No show fees for missed appointments are $35. Late arrivals will be rescheduled to the next available time.

We accept, cash, credit cards, or personal checks for payment. There is a service fee of $50 for any returned checks. Credit card information may be stored on file *at your request* for deposit, future, or re-occurring payments. *Delinquent or past due balances over 90 days will be billed to credit card information stored on file.*

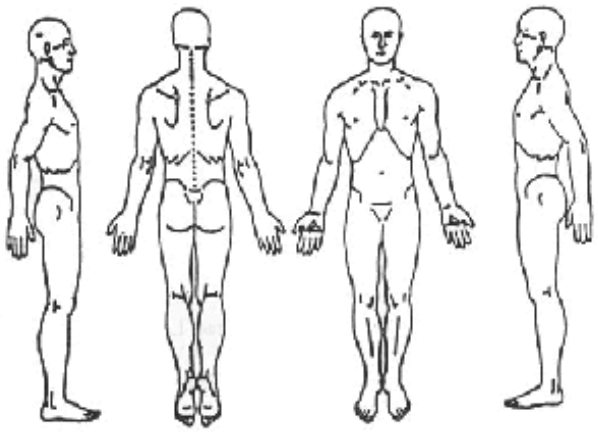
I grant permission to be contacted to confirm or reschedule an appointment, and to be sent occasional letters, emails, or other health information to me as an extension of care in this office.

Printed name: _____ Signature: _____ Date: _____

Name: _____

Date: _____

MARK AN 'X' WHERE IT HURTS



PATIENT HISTORY

What is your main complaint today? _____

When did these symptoms start *(provide date MM/DD/YYY):* _____

Are these symptoms related to ☐ Auto Injury ☐ Work Injury

On the scale below, please circle the severity of your main complaint (at it's worst)

1	2	3	4	5	6	7	8	9	10

What does your symptom feel like? *check one or all that apply*

☐ Dull ☐ Aching ☐ Throbbing ☐ Sharp ☐ Stabbing ☐ Burning ☐ Numbing/Tingling ☐ Cramping ☐ Stiffness

☐ Other: _____

When do you experience or notice these symptoms most? ☐ Morning ☐ Evening ☐ ALL THE TIME

On the scale below, please circle the percentage of time you experience your main complaint:

0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Does the symptom radiate or travel to other areas of your body? ☐ No ☐ Yes If yes, where: _____

Do the following movements or activities aggravate your symptoms? *check all that apply*

☐ Walking ☐ Standing ☐ Sitting ☐ Bending ☐ Lifting ☐ Climbing ☐ Sitting to Standing ☐ Standing to Sitting ☐ Driving ☐ Sports

Does the symptom interfere or effect: ☐ sleep (interrupt or wake you) ☐ work (have you missed work because of symptom)

☐ studying ☐ housework/chores ☐ personal grooming (showering, dressing, etc.)

Have you tried to relieve symptoms? ☐ No ☐ Yes If yes, with what? ☐ Pain Medication ☐ Ice ☐ Heat ☐ Massage ☐ Stretching

Have you been treated for this condition before? ☐ No ☐ Yes (If yes, provide date MM/YYYY) _____

REVIEW OF SYSTEMS: *Please check of any conditions you had or currently have:*

Musculoskeletal

☐ Osteoporosis ☐ Arthritis ☐ Shoulder Problems ☐ Knee Problems ☐ Hip Disorders ☐ Foot/Ankle Pain ☐ Elbow/Wrist Pain

☐ Neck Pain ☐ Back Problems ☐ Poor Posture ☐ Scoliosis ☐ TMJ Issues

Neurological

☐ Numbness ☐ Pins and Needles ☐ Headaches ☐ Dizziness ☐ Anxiety ☐ Depression

Cardiovascular

☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol ☐ Poor Circulation ☐ Excessive Bruising

Respiratory

☐ Asthma ☐ Apnea ☐ Emphysema ☐ Hay Fever ☐ Shortness of Breath ☐ Pneumonia

Digestive

☐ Anorexia/Bulemia ☐ Ulcer ☐ Heartburn ☐ Constipation ☐ Diarrhea ☐ Food Sensitivities

Skin

☐ Skin Cancer ☐ Psoriasis ☐ Eczema ☐ Acne ☐ Hair Loss ☐ Rash

Endocrine

☐ Diabetes ☐ Thyroid Issues ☐ Hypoglycemia ☐ Frequent Infection ☐ Swollen Glands ☐ Low Energy

Genitourinary

☐ Kidney Stones ☐ Infertility ☐ Bedwetting ☐ Prostate Issues ☐ Erectile Dysfunction ☐ PMS Symptoms

☐ Are you pregnant? ☐ Yes ☐ No

☐ Number of pregnancies: _____ Natural Births: _____ Caesarian: _____

☐ What was the first date of your last menstrual cycle? _____

CURRENT MEDICATIONS: ☐ None

_____

ALLERGIES: ☐ None

_____

SURGICAL HISTORY: ☐ None

_____

SOCIAL HISTORY: Do you use tobacco: ☐ No ☐ Prior ☐ Yes How often? _____ How many years? _____

How many glasses of water do drink a day? _____ Do you drink caffeinated beverages? ☐ No ☐ Yes How many a day? _____

Do you exercise regularly? ☐ No ☐ Yes If yes, how often? ☐ Daily ☐ Weekly What type of activity? _____

FAMILY HISTORY OF DISEASE: ☐ Unknown ☐ Maternal ☐ Paternal : ☐ Heart Disease ☐ Cancer ☐ Other _____

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ACKNOWLEDGEMENTS

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement and sign your agreement.

PRIVACY POLICY

For use and/or disclosure of protected health information (PHI) to carry out treatment, payment, and healthcare operations. I hereby state that by signing this consent, I agree and acknowledge as follows: Lincolnwood Chiropractic Health Center's Notice of Privacy Practices has been provided to me prior to my signing this consent.

The Notice of Privacy Practices includes a complete description of the uses and/or disclosure of my Protected Health Information ("PHI") necessary for Lincolnwood Chiropractic Health Center to provide treatment to me, and also necessary to obtain payment for that treatment and to carry out it's health care operations.

Lincolnwood Chiropractic Health Center reserves the right to change its Privacy Practices that are described in its Notice of Privacy Practices, in accordance with applicable law. I also have the right to obtain any revised notices at Lincolnwood Chiropractic Health Center.

Lincolnwood Chiropractic Health Center may communicate with my primary care physician and/or other health care providers to provide me with optimum health care. If this is necessary, copies of my medical records will be submitted to my primary care physician and/or other health care providers for coordination of my care and treatment.

Lincolnwood Chiropractic Health Center has the right to release my medical information necessary to process insurance claims. The Notice of Privacy Practices also describes my rights and the duties of this office with respect to my Protected Health Information.

INFORMED CONSENT

I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in the practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

I consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future work at Lincolnwood Chiropractic Health Center. I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

I HAVE READ AND FULLY UNDERSTAND THIS PRIVACY POLICY AND CONSENT TO TREATMENT FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

Printed name: _____ Signature: _____ Date: _____

CONSENT TO EXAMINATION AND CARE BY LINCOLNWOOD CHIROPRACTIC HEALTH CENTER

As a patient, you are entitled to be informed the purpose, benefits, and potential risks of a health care procedure, and to make the decision about whether or not to undergo the procedure. **Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.**

The Nature of the Chiropractic Adjustment

A primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy (also called "chiropractic adjustment"). If I believe it is indicated in your case, I will use this treatment by placing 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.

Other Examinations, Tests, and Treatments

In addition, I may use other tests and examinations, some of which are listed below, if I believe they are warranted based on your condition and the information you give me. As a part of the analysis, examination, and treatment, you are consenting to the following procedures, except those that you select below:

- Spinal Manipulative Therapy
- Palpation
- Vital signs
- Range of motion testing
- Orthopedic testing
- Basic Neurological Muscle Strength Testing
- Postural Analysis
- Ultrasound
- Hot/Cold Therapy
- Electrical Muscle Stimulation
- Mechanical Traction
- Massage Therapy
- Acupuncture

Material Risks Of Chiropractic Adjustment

As with any healthcare procedure, certain complications 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 some 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.

Probability of Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare. In 2008, one study reported the risk to be 1 case per 400,000 to 1,000,000 cervical spine adjustments. To the best of my knowledge, this is the largest controlled research study to date on this issue. Please ask if you would like additional information regarding cervical spine adjustments and risk of stroke. The other complications are also generally described as rare.

Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

• Self-administered, over-the-counter analgesics and rest – risks may include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

• Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers - typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
• Hospitalization -- risk of exposure to infection and/or communicable disease in a significant number of cases.
• Surgery -- risk of adverse reaction to anesthesia, as well as an extended recovery period in a significant number of cases.

If you choose to use one of the above noted "other treatment" options, you should discuss their risks and benefits with your primary medical or osteopathic physician.

Risks of Remaining Untreated
Delay of treatment may allow formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. Therefore, delay of treatment may complicate the condition and make future rehabilitation more difficult.

I have fully explained to you the risks and benefits of undergoing this procedure, as well as the risks and benefits of declining to undergo this procedure.

Risk of COVID-19
The World Health Organization has declared COVID-19 to be a pandemic, the first to be caused by Coronavirus. This office follows all CDC-recommended steps for infection control, including appropriate staff and patient screening (e.g., temperature, cough, breathing difficulties, recent travel, any exposure to COVID-19); all cleaning/disinfecting protocols; and social distancing requirements. However, even strict adherence to these procedures cannot guarantee the complete absence of the Coronavirus in my office (or in any location), nor can it guarantee that Coronavirus transmission will never occur. Please ask if you have any questions regarding our infection control procedures. By signing this form, you acknowledge our infection control procedures and understand that this office cannot completely eliminate the risk of exposure to COVID-19 on our premises.

For Parent or Guardian Signing Form on Behalf of Patients Under 18 Years of Age
This office observes all laws regarding a minor patient's right to consent to, and to confidentiality of, his or her health care treatment. In addition, this office follows a policy of transitioning adolescent patients to self-management of their own health. We view our office visits as an opportunity for your child to learn to take responsibility for their health care. Therefore, as appropriate by age and maturity of the patient, parents may be asked to excuse themselves for a portion of or the entire health care visit. By signing this form, the parent or responsible party acknowledges understanding of and consent to this policy.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment, as outlined in this document. I have discussed it with Dr. Evana Younan D.C. and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks and benefits involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I understand that the doctor will use her best professional judgment but cannot and does not guarantee any outcome or results. Having been informed of the risks, I hereby give my consent to treatment as outlined in this document.

Date: _____

_____ _____
Patient Name Patient Signature

OR

_____
Signature of Responsible Party (IF OTHER THAN PATIENT)

_____
Responsible Party's Relationship to Patient
(Enter Parent or Guardian if patient is not legally authorized to consent to his/her own health care.)