Complete Rehabilitation

p. 708.354.9599
f. 708.354.9799

442 Sherwood Road
LaGrange Park, IL 60526

www.CompleteRehabilitation.net

Patient Information

Date: _____

First Name: _____ MI:____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: M / F Date of Birth: _____ Marital Status: S M W D Other

Phone Number: (H) _____ (W) _____ (C) _____

E-mail: _____

Occupation: _____ Employer: _____

Primary Physician: _____Address: _____

City: _____ State:____ Zip:_____ Phone Number: _____

If you would like a report sent to your primary physician sign here: _____

How were you referred to our office: _____

Insurance Carrier: _____ **A copy of your photo ID and insurance card must be on file.**

Name of Insured: _____ Relationship to insured: Self Spouse Child

Insured Date of Birth:_____ Insured Social Security No.: _____

Emergency Contact Information:

Name:_____ Telephone Number: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Complete Rehabilitation. I understand and agree to allow Complete Rehabilitation to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of healthcare regardless of insurance coverage. I also understand it is my responsibility to obtain and understand the benefits from my insurance company. I request that Complete Rehabilitation, Ltd. prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Complete Rehabilitation, Ltd. that fees will be due and payable immediately; and that interest is charged on overdue accounts at the annual rate of 16%. I understand that should any unpaid balance due that I owe be placed with a third party debt collection agency or attorney, an additional 40% of the unpaid balance along with all attorneys fees will be added to reimburse Complete Rehabilitation for the costs of collections.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

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PATIENT NAME: _____ DATE: _____

Do you or have you experienced any of the following?

1. Vertigo (dizziness) Yes _____ No _____
2. Fainting Yes _____ No _____
3. Double vision Yes _____ No _____
4. Difficulty walking Yes _____ No _____
5. Stroke Yes _____ No _____
6. Cancer Yes _____ No _____
7. Night sweats Yes _____ No _____
8. Ringing in ears Yes _____ No _____
9. Smoker Yes _____ No _____
10. Alcohol use Yes _____ No _____
15. Headaches lasting hours or days Yes _____ No _____
16. Change of bowel or bladder habits Yes _____ No _____
17. Nagging cough or hoarseness Yes _____ No _____
18. Pain in neck, jaw or face Yes _____ No _____
19. Do you take birth control pills? Yes _____ No _____
20. Does pain wake you from sleep Yes _____ No _____
21. Are you losing weight now without trying? Yes _____ No _____

11. Are you currently seeing another doctor and for what reason? Yes _____ No _____
    Reason: _____

12. What was the date of your last physical exam? _____

13. What prescription medication are you currently taking and for what reason?
    [ ] High blood pressure medication
    [ ] Blood thinners
    [ ] Other

    _____
    _____

26. Please indicate any other medical information (hospitalizations, fractures, surgeries, car accidents):

    _____
    _____

Family History

Did your mother or father have any of the following:

Put an **M** for mother, **F** for father, and **B** for both.

( ) High Blood Pressure
( ) Heart Attack
( ) Stroke
( ) Emphysema
( ) Asthma
( ) Thyroid Disease
( ) Diabetes
( ) Circulation Problems
( ) Cancer
( ) Arthritis-Rheumatism
( ) Kidney Disease
( ) Seizure-Convulsions

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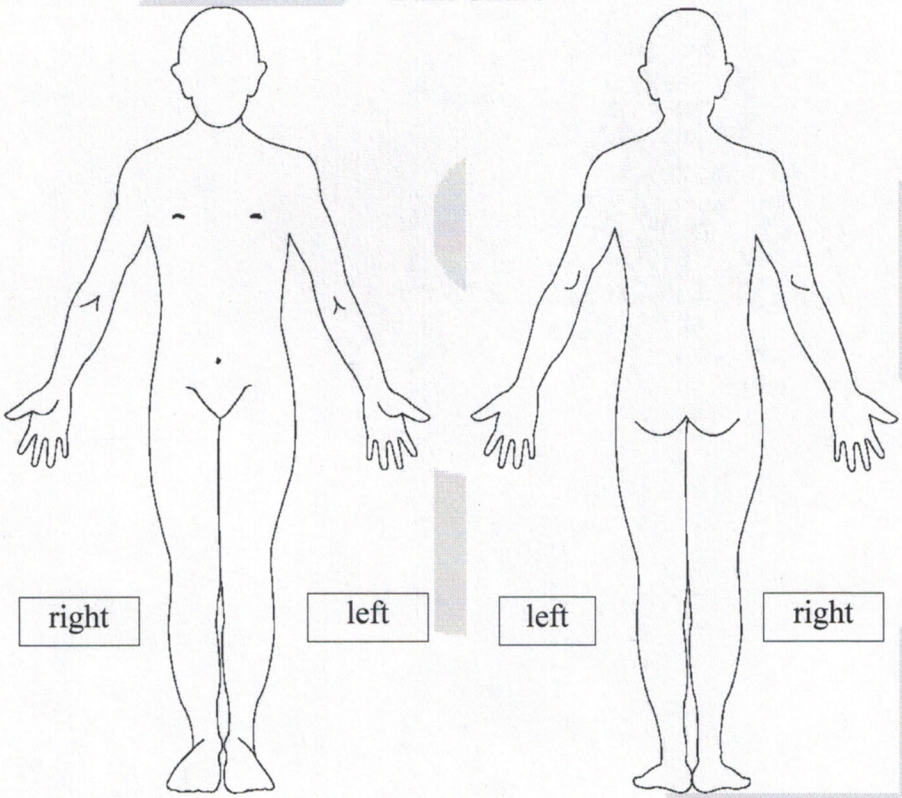
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /

Pain Chart

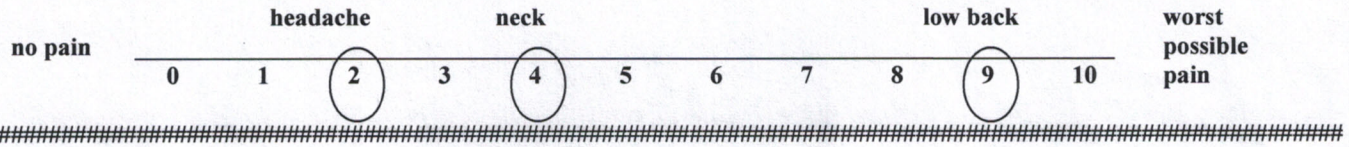


Date: _____ Signature _____

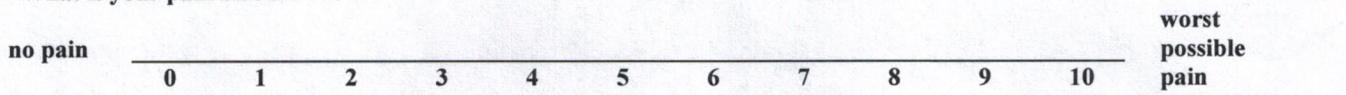
QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

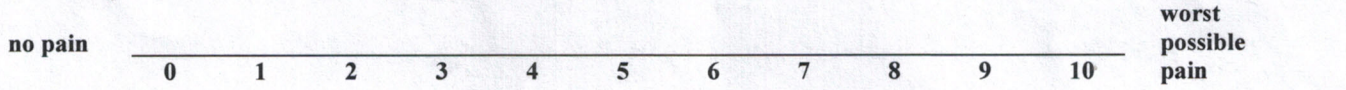
EXAMPLE:



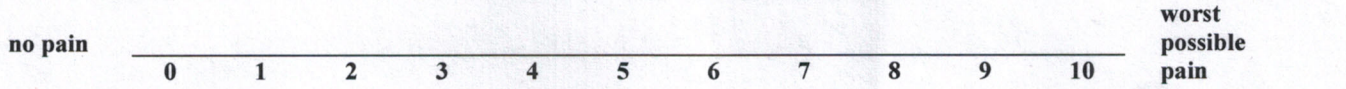
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

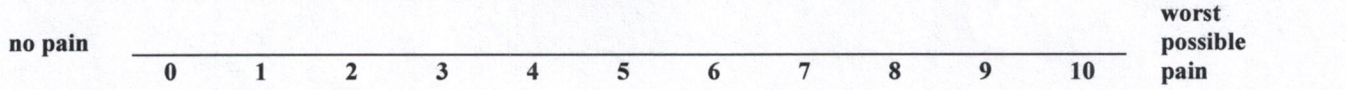


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

NAME _____ **AGE**_____ **DATE**_____ **SCORE**_____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning these records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Signature of Patient **Date**