Ridge Chiropractic Center
104 Ridge Rd., Suite 144, Minooka, IL 60447

Darren Cissell, D.C.
Phone: 815-467-1464 Fax: 815-521-0492

CONFIDENTIAL PATIENT INTAKE FORM

Thank you for choosing Ridge Chiropractic Center

IMPORTANT: If you are using insurance to supplement your care, present your insurance card(s) and I.D. to our front staff.

Bring any old or new X-Rays or MRI reports please. It may help the doctor.

Print clearly and check the appropriate boxes. Do not skip any questions. This is an important part of establishing medical necessity.

Date _____ Whom may we thank for referring you? _____

Patient Name _____ ☐ Male ☐ Female Age _____ Birth Date _____
Last Name First Name Initial

Home Phone _____ Cell Phone _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact _____ Relationship _____ Phone _____

EMPLOYMENT INFORMATION

Work Status ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Student ☐ Minor

Occupation _____ Physical Work Duties _____

INSURANCE INFORMATION

Person Responsible for Account _____ Birth Date _____ _____
Last Name First Name Initial Insurance Company

Relationship to Patient _____ Cell Phone _____ Social Security # _____

Address (If different from patient's) _____ City _____ State _____ Zip _____

Is the patient covered by additional or secondary insurance? ☐ No ☐ Yes

REASON FOR THIS VISIT

This is a: ☐ New condition ☐ Flare-up ☐ Injury ☐ Chronic Discomfort ☐ Other (explain) _____

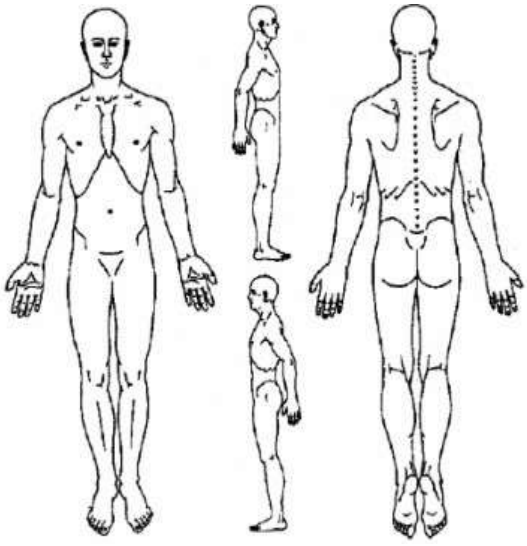
What caused this condition? Explain and check appropriate box(es) _____

☐ Not sure	☐ Work Injury	☐ After a poor night's sleep	☐ Yard work	☐ Prolonged illness
☐ Sports Injury	☐ After a slip / fall	☐ After lifting an object	☐ Sitting too long	☐ Household chores
☐ Auto Accident	☐ After a long drive / flight	☐ Reaching or overarching	☐ Other (explain) _____	

When did your symptoms start (most recent date)? _____ **What was the onset?** ☐ Gradual ☐ Sudden

Have you had this condition before? ☐ No ☐ Yes If yes, when? _____

PLEASE READ: Circle any and all areas on the diagram below that bother you or that you want treated. Then, starting with your primary complaint, list all symptoms you circled on the diagram. *For example:* ***Body Area / Symptom #1:*** *Left Neck Pain / Headache;* ***Body Area / Symptom #2:*** *Lower Back Spasms, Right Leg Tingling, etc.* **Next,** on a scale from 0 to 10, with 10 being the worst, circle the number that best describes your symptom(s) at their worst lately. **Finally,** check the percent of the day you feel your symptom(s):



Body Area / Symptom(s) #1: _____

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

% of Day ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Body Area / Symptom(s) #2: _____

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

% of Day ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Body Area / Symptom(s) #3: _____

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

% of Day ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Body Area / Symptom(s) #4: _____

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

% of Day ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

My initials certify that the above information is true and complete to the best of my knowledge. Patient (or Guardian's) initials_____ Date_____

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Patient Name _____ Date _____

If your answers to the following questions 1 through 5 vary for each symptom listed on the previous page, ask for 'Additional Symptoms" page from our staff.

1. Check ALL that aggravate your symptom(s)

☐ Bending Neck Forward ☐ Turning Head to Right ☐ Twisting Left at Waist ☐ Sitting ☐ Running
☐ Bending Neck Backward ☐ Bending Forward at Waist ☐ Twisting Right at Waist ☐ Standing ☐ Changing Positions
☐ Tilting Head to Left ☐ Bending Backward at Waist ☐ Getting Up from Sitting ☐ Lifting ☐ Chewing
☐ Tilting Head to Right ☐ Tilting Left at Waist ☐ Coughing/Sneezing ☐ Driving ☐ Climbing Stairs
☐ Turning Head to Left ☐ Tilting Right at Waist ☐ Any Movement ☐ Walking ☐ Other (Explain) _____

2. Check ALL that relieve your symptom(s)

☐ Nothing ☐ Sitting ☐ Heat ☐ Exercise ☐ Standing ☐ Muscle Relaxers ☐ Chiropractic ☐ Massage
☐ Resting ☐ Ice ☐ Stretching ☐ Walking ☐ Pain Medication ☐ Physical Therapy ☐ Other (explain) _____

3. Check ALL that describe your symptom(s)

☐ Achy / Dull / Stiff ☐ Sharp / Stabbing ☐ Shooting / Radiating ☐ Throbbing ☐ Numbness ☐ Pins/Tingling ☐ Swelling
☐ Tight / Spasms ☐ Burning ☐ Nagging ☐ Other (Explain) _____

4. Is the symptom(s) worse at certain times of the day or night? (check ALL that apply):

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by the time of day

5. Does the symptom(s) radiate, shoot or travel to another part of your body? ☐ No ☐ Yes If yes, where? _____

What have you done to relieve your symptom(s)?

☐ Nothing ☐ Prescription medication ☐ Physical therapy ☐ Massage ☐ Ice ☐ Acupuncture
☐ Rest ☐ Over-the-counter drugs ☐ Chiropractic ☐ Surgery ☐ Heat ☐ Other (Explain) _____

Were any other doctors or therapists seen for this condition? ☐ No ☐ Yes

If yes, list all doctors or therapists, approximate date of visit(s), diagnosis, and tests findings such as X-rays, MRI's, etc. and **provide us with reports / CD's if possible**.

Name	Date of Visit	Diagnosis	Test and Findings

Have you missed any work as a result of your condition? ☐ n/a ☐ No ☐ Yes (list dates) _____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Ht ___'_____". Wt _____ lbs. Blood Pressure _____ /_____. Last Physical Exam Date _____. Physician's Name _____

Please list **any** health conditions / diagnosis that you have been treated for in the past (condition, cause, current / resolved) _____

Previous surgeries, hospitalization? ☐ No ☐ Yes (list dates and details) _____

List any current medications, prescription, over-the-counter, natural supplements, dose, frequency and reason (Provide list if needed) ☐ **None**

Previous auto accident(s) EVER? ☐ No ☐ Yes (list dates and details) _____

Previous injury, trauma, broken bones? ☐ No ☐ Yes (list dates and details) _____

Are you allergic to anything? ☐ No ☐ Yes (please list) _____

Have you had previous chiropractic care? ☐ No ☐ Yes (last visit date and condition being treated for) _____

Any family history of disease or hereditary conditions? ☐ No ☐ Yes (list dates and details) _____

Cause of immediate family deaths and age at death _____

Smoking Status (Age 13 and over) ☐ Never A Smoker ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Occasional Smoker

How is your diet? ☐ Poor ☐ Fair ☐ Good ☐ Eat very healthy **How often do you eat out?** _____

Drink Alcohol? ☐ No ☐ Yes (How much?) _____ **Soft drinks** ☐ No ☐ Yes (How much per day?) _____

Drink Coffee? ☐ No ☐ Yes (How much per day?) _____ **Water intake** ☐ No ☐ Yes (How much per day?) _____

Exercise? ☐ No ☐ Yes (How often?) _____ **Your average sleep per night** _____ Hours

Daily stress level ☐ Low / None ☐ Moderate ☐ High **What is the major stressor in your life?** _____

Your current hobbies, sports and recreation _____

(Female Only) Are you **pregnant**, or have you had any signs of pregnancy? ☐ No ☐ Yes

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Patient Name _____ Date _____

REVIEW OF SYSTEMS

Please check any condition that you've HAD, currently HAVE or check "None" if you've never had any conditions in each section.

Muscle and bone-related History (Musculoskeletal)

Had	Have		Had	Have		Had	Have	
☐	☐	Arthritis	☐	☐	Hip Disorders	☐	☐	**Scoliosis**
☐	☐	Back Problems / **Disc Hernia**	☐	☐	Knee Injuries	☐	☐	**Spinal Fracture**
☐	☐	Elbow/Wrist Pain	☐	☐	**Metal Implants**	☐	☐	**Spinal Surgery**
☐	☐	Foot/Ankle Pain	☐	☐	Neck Pain	☐	☐	Shoulder Problems
☐	☐	Gout	☐	☐	**Osteoporosis (Severe)**	☐	☐	TMJ issues

☐ **None**

Nerve-related History (Neurological)

Had	Have		Had	Have		Had	Have	
☐	☐	Headache	☐	☐	Memory Issues	☐	☐	**Stroke / TIAs**
☐	☐	Loss of Smell or Taste	☐	☐	**Seizures**	☐	☐	Temporary Loss of Vision

☐ **None**

Heart-related History (Cardiovascular)

Had	Have		Had	Have		Had	Have	
☐	☐	Angina/Chest Pain	☐	☐	Heart Issues	☐	☐	High Cholesterol
☐	☐	**Blood clots**	☐	☐	High Blood Pressure	☐	☐	**Pacemaker**

☐ **None**

Lung-related History (Respiratory / Pulmonary)

Had	Have		Had	Have		Had	Have	
☐	☐	Apnea	☐	☐	COPD	☐	☐	Pneumonia
☐	☐	Asthma	☐	☐	Emphysema	☐	☐	Shortness of Breath

☐ **None**

Stomach-related History (Digestive / Gastroenterology)

Had	Have		Had	Have		Had	Have	
☐	☐	Anorexia/Bulimia	☐	☐	Diarrhea	☐	☐	Heartburn
☐	☐	Constipation	☐	☐	Food Sensitivities	☐	☐	Ulcers

☐ **None**

Kidney-related History (Genitourinary / Renal)

Had	Have		Had	Have		Had	Have	
☐	☐	Erectile Dysfunction	☐	☐	Kidney Stones	☐	☐	Prostate Issues
☐	☐	Infertility	☐	☐	PMS Symptoms	☐	☐	**Urinary Incontinence**

☐ **None**

Glandular and hormonal-related History (Endocrinology)

Had	Have		Had	Have		Had	Have	
☐	☐	**Diabetes**	☐	☐	Hormonal Issues	☐	☐	Steroid Treatments
☐	☐	Frequent Infection	☐	☐	Swollen Glands	☐	☐	Thyroid Issues

☐ **None**

Blood-related History (Hematology/Lymph)

Had	Have		Had	Have		Had	Have	
☐	☐	Anemia	☐	☐	**Bleeding Disorder**	☐	☐	Swollen Lymph Nodes

☐ **None**

Psychology History

Had	Have		Had	Have
☐	☐	Anxiety / Depression	☐	☐ Psychiatric diagnosis: _____

☐ **None**

Skin-related History (Dermatology / Integumentary)

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

☐ **None**

Constitutional History

Had	Have		Had	Have		Had	Have	
☐	☐	Fainting	☐	☐	Low Libido	☐	☐	Sudden Weight Loss
☐	☐	Fever	☐	☐	Poor Appetite	☐	☐	Sudden Weight Gain

☐ **None**

Check any of the following other issues you have

☐ Alcoholism	☐ Bronchitis	☐ Fatigue	☐ Miscarriage	☐ Varicose Veins
☐ **ALS**	☐ **Cancer**	☐ Frequent Urination	☐ **Multiple Sclerosis**	☐ Weakness
☐ **Aneurysm**	☐ **Cauda Equina Syndrome**	☐ Hemorrhoids	☐ **Rheumatoid Arthritis**	☐ **Unstable Os odontoideum**
☐ **Ankylosing Spondylitis**	☐ Cold Extremities	☐ Irregular Menstrual Cycle	☐ **Radiculopathy with progressive neurological signs**	
☐ Arteriosclerosis	☐ Dizziness	☐ Kidney Infection	☐ Sleep Problems/Insomnia	☐ **Vertebral Column Malignancy**
☐ **Bone Tumor of Spine**	☐ Excessive Menstruation	☐ Lyme Disease	☐ Swollen Joints	☐ **Vertebrobasilar Insufficiency**
☐ Breast Lump	☐ Eye Pain or Difficulties	☐ Migraines		☐ **None**

Is there anything else the doctor should know about in your past or present medical history, health or ways your current condition is affecting your life?

_____

_____

My initials certify that the above information is true and complete to the best of my knowledge. Patient (or Guardian's) initials_____ Date_____

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AUTHORIZATION FOR CARE

I certify that I am the patient or legal guardian listed above. I consent to the collection and use of the above information for the use within this office of chiropractic and do hereby authorize and release the Doctor and whomever he may designate as his assistants to administer treatment, physical examination, diagnostic x-ray studies, chiropractic care, and all other therapeutic procedures provided at Ridge Chiropractic Center, by any means, method, and or techniques, the doctor deems necessary to determine and treat my or my child's condition at any time throughout the entire clinical course of my or my child's care or in accordance with this state's statutes. As with any healthcare procedure, I understand there some risks to chiropractic manipulation and therapy including, but not limited to: fractures (which are rare and generally result from some underlying bone weakness), stroke (which is exceedingly rare and estimated to occur between one in one million and one in five million cervical adjustments), spinal or disc injuries, dislocations, and strains/sprains, and am willing to accept and consent to treatment. The other complications are also generally rare. I understand that the practice of chiropractic medicine is not an exact science and that care may involve the making of judgements based on 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 judgement or treatment; that no guarantee as to results has been made to or relied upon by me, and the doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I wish to rely on the doctor to exercise judgement during the course of the procedure which he or she feels at the time, based on the facts then known.

CONSENT TO TREAT A MINOR: I hereby affirm that I have to legal right to select and authorize health care services for my minor child named above. (if applicable) Under the terms and conditions of my dissolution of marriage or separation, I have the legal right to select and authorize this care for my minor child without consent of my spouse/former spouse. If my authority to authorize such care is revoked or modified, I will immediately notify this office. 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. I hereby authorize Ridge Chiropractic Center and whomever they may designate as doctors, assistants, and therapists to examine and administer treatments as they deem necessary to my child in my presence or absence under normal office visit circumstances.

TERMS OF ACCEPTANCE: When a patient seek chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation (segmental and somatic dysfunction). Our chiropractic method of correction is by specific adjustments to the spine. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease. Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation (segmental and somatic dysfunction). However, if during the course of a chiropractic spinal evaluation we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you or your child seek the services of a health care provider who specialized in that area. Regardless of what the disease is called, we do not offer to treat it nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation (segmental and somatic dysfunction).

RADIOLOGY REPORT: I hereby consent to a full examination and x-ray studies, and also understand and **I do hereby consent to have the doctor send my x-rays out to be read professionally by a radiologist, Dr. Gregerson**, who may or may not be in my or my child's health plan, as is the standard in the medical community. Dr. Gregerson's office will bill you separately from our office, Ridge Chiropractic Center. I am only entitled to a copy of this written imaging report. I further understand and agree that the payments to the doctor for x-rays is for examination of x-rays only and agree that x-rays are the sole legal property of this practice and must be retained for a period of no less than 8 years and are kept on file where they may be seen at any time while I am a patient at this office.

HIPAA NOTICE OF PRIVACY PRACTICES: This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes a complete description of the uses and/or disclosures of your PHI necessary for this office to provide treatment to you or your child, to obtain payment for that treatment from any involved third parties, and to carry out its health care operations as is permitted or required by law. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice also describes how you can get access to that information and details your rights regarding your PHI. This Practice's "HIPAA Notice of Privacy Practices" may be requested at any time from the front desk staff and is also provided on the Practice's web site at MinookaChiropractor.com in the tab labeled "What to Expect" under "Online Forms". PLEASE REVIEW THIS NOTICE CAREFULLY.

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the use of my signature on all insurance submissions, and **I understand that Ridge Chiropractic Center will prepare any necessary reports and forms to assist me in collecting from the insurance company.** I further authorize Ridge Chiropractic Center to disclose all or any part of my or my child's patient records to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

If my insurance will be billed, I authorize payment to be made directly to Ridge Chiropractic Center, for all benefits that may be payable under a healthcare plain or from any other collateral sources. I authorize utilization of this form or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that **I will remain financially responsible for any and all covered or non-covered services I receive at this office.** All first visit charges are payable when services are rendered, since it is impossible to determine insurance coverage without a diagnosis of severity.

I have read and fully understand the above and certify that the information I have provided is true and correct to the best of my knowledge and I will not hold the doctor or any staff member at Ridge Chiropractic Center responsible for any errors or omissions that I may have made on this form. I do hereby authorize the doctor to treat myself or my child in accordance with this state's statutes.

_____	_____	_____
Name of Patient (Printed)	Signature of Patient	Date
_____	_____	
(Signature of Legal Representative if patient a minor)	Relationship (e.g. Guardian or Parent if patient a minor)	

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FUNCTIONAL RATING INDEX

For use with **Neck and/or Back Problems** only.

Patient Signature _____ Date _____

In order to properly assess your condition, we must understand how much **your neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderate disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus Unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Can not work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Can not do any activities

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/ 2 hour	Increased pain with any standing

_____
Examiner