Application for Patient Care

PATIENT INFORMATION:

Name: ___________________________________ DOB: ______ /______/______

Address: _________________________________ SS#:_______-_____-______

City, State, Zip : ___________________________ Emergency Contact: _________________________

Marital Status: S M D W Sex: M F Relationship: _______________________________

Phone #: _________________________________ Phone #: _______________________________

Email: ___________________________________

Primary Care Physician:_________________________________ Phone: _______-_______-_______

Can we contact your doctor regarding your care in our office? Yes / No

Occupation:____________________ Employer:___________________ Work Phone:_____-_____-_______

Types of tasks performed/common movements:____

ACCIDENTS:

Have you had an auto accident:

☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have you had a recent fall/other accident:

☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have you ever received chiropractic care?

☐ Yes ☐ No Last Visit:_______________

REFERALS:

How Did You Hear About This Office?

☐ Walk-In/Drive-By ☐ Community Event:

☐ Existing Patient: ________________________

☐ Internet: _______________________________

☐ Other: _________________________________

INSURANCE:

Primary Insurance Carrier: ______________________

ID Number: __________________________________

Group Number: _____________________________

Policy Holder: ______________________________

Relationship to Patient: _______________________

Birth Date: __________________________________

Secondary Insurance Carrier: _____________________

ID Number:____________________________________

Group Number: _______________________________

Policy Holder: ________________________________

Relationship to Patient: _________________________

Birth Date: ___________________________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

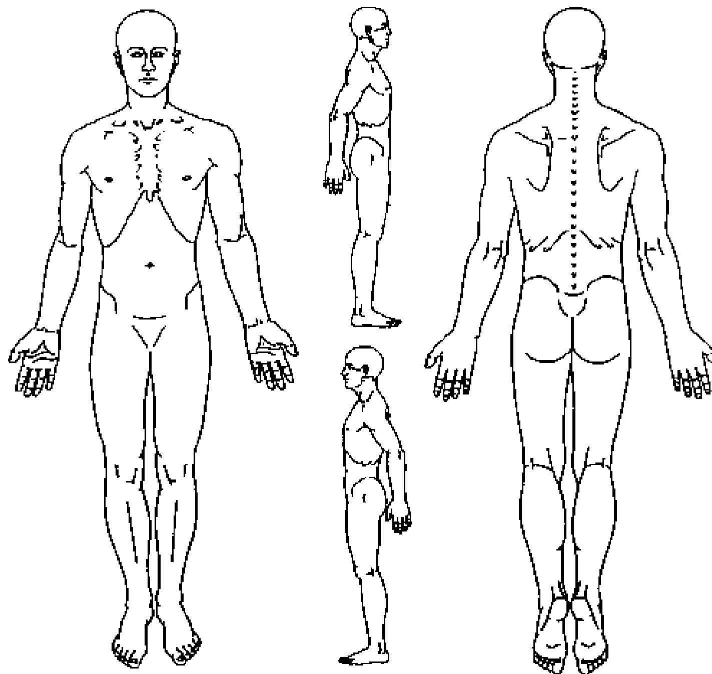
I certify that I (or my dependent) have insurance coverage with ____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, ProActive Chiropractic & Laser Center, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ____________________________________ **DATE** ______________________

PATIENT HEALTH HISTORY

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

☐Neck Pain/Stiffness ☐Pins/Needles in Arms
☐Back Pain/Stiffness ☐Pins/Needles in Legs
☐Arm/Hand Pain ☐ Light Bothers Eyes
☐Leg/Knee Pain ☐ Weight Change + / -
☐Headaches ☐ Loss of Memory
☐Night Pain ☐ Nausea
☐Depression ☐ Loss of Taste
☐Cold Extremities ☐ Fatigue
☐Nervousness ☐ Chest Pain
☐Trouble Sleeping ☐Tension
☐Jaw Problems ☐ Fever
☐Loss of Smell ☐ Cold Sweats
☐Fainting ☐ Constipation/Diarrhea
☐Dizziness ☐ Allergies
☐Stomach Problems ☐ Shortness of Breath
☐Asthma ☐ Blurred/Double Vision
☐Swollen Joints ☐ Bowel/Bladder Changes
☐Mood Changes ☐ Trouble Concentrating
☐Foot Trouble ☐ Loss of Balance



Please check if you have ever had any of the following:

*****CIRCLE AREAS OF CONCERN ON THE BODY DIAGRAM*****

☐ADD/ADHD
☐Aids/HIV
☐Alcoholism
☐Allergy Shots
☐Anemia
☐Anorexia
☐Appendicitis
☐Arthritis
☐Asthma/Wheezing
☐Bad Breath/Bad Taste
☐Bleeding Disorders
☐Blood Pressure: High or Low (circle)
☐Breast Lump
☐Broken Bones
☐Bronchitis
☐Bulimia
☐Cancer
☐Cataracts
☐Chemical Dependency
☐Chicken Pox
☐Colon Trouble
☐Contacts/Glasses
☐Diabetes
☐Dry Skin
☐Ear Infections
☐Epilepsy
☐Fractures
☐Gall Bladder
☐Glaucoma
☐Goiter
☐Gonorrhea
☐Gout
☐Heartburn
☐Heart Attack
☐Heart Problems
☐Hemorrhoids
☐Hepatitis
☐Hernia
☐Herniated Disc
☐Herpes
☐High Cholesterol
☐Hormone Imbalance
☐Insomnia
☐Kidney Problems
☐Liver Disease
☐Measles
☐Menopausal Prob.
☐Migraines
☐Miscarriage
☐Mononucleosis
☐Mouth Sores or Bleeding Gums
☐Multiple Sclerosis
☐Mumps
☐Nosebleeds
☐Osteoporosis
☐Pacemaker
☐Parkinson's Disease
☐Pinched Nerve
☐Pneumonia
☐Polio
☐Prostate Problems
☐Prosthesis
☐Psychiatric Care
☐Rheumatoid Arthritis
☐Rheumatic Fever
☐Scarlet Fever
☐Sexual Difficulty
☐Stroke
☐Suicide Attempt
☐Thyroid Problems
☐TMJ Pain
☐Tonsillitis
☐Tremors
☐Tuberculosis
☐Tumors/Growths
☐Typhoid Fever
☐Ulcers
☐Vaginal Infections
☐Venereal Disease
☐Whooping Cough
☐Other: __________
____
____
____

Are you currently under drug and/or medical care? ☐Yes ☐No If yes, explain:
____
____

Reason for visit today: (Conditions, Symptoms, or anything you would like to discuss)
____
____

SIGNATURE (X) ________________________________ **DATE** ____________________

2535 Bethany Rd. Suite 100 Sycamore, IL 60178 Ph: (815) 517-0826 Fax: (815) 517-0826

Personal Medical History: (Circle if applies)

Diabetes | High Blood Pressure | Pacemaker
Heart Disease | Stroke | Fibromyalgia
Thyroid | Other:____

Family History: (Circle if applies and list the family member and the type of condition if applies)

Inflammatory Arthritis | Heart Disease | Cancer
Stroke | Diabetes
Other: ____

History of Trauma:

Auto (Date):_____________________________ Slip/Fall (Date):_______________________________________
Auto (Date):______________________________Sport:____
Auto (Date): _____________________________ Work:____
Other:__________________________________ Other:____

Please list any surgeries and/or hospitalizations you have had (type & date):

____
____
____

ALLERGIES: **(Please place a check mark next to any known allergy that you have)**

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy
___Wheat ___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin
___Carbamazepine ___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen
___Weed Pollen ___Insects ___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___
OTHER: _________________/__________________/________________/___________________ (please fill in)

Medications:____
____
____

Supplements:

____
____

Hobbies:

____

Have you had to give up your hobbies or modify performing them due to your pain? (Please Circle) Yes / No

Prior Chiropractic experience:____

How Does Your Pain Impact Your Activities of Daily Living?
Home/Recreational:____
____
____

Work:____
____
____

SIGNATURE (X) ____ DATE _____________

Social History:

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Have you had to give up exercising or modify because of your pain? Yes / No

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Hours per day spent: Sitting ___________ Standing ____________

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following?

Caffeine_________ cups/day Alcohol ________ drinks/week Cigarettes ____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam.

SIGNATURE (X) ______________________________________ **DATE** ________________________

X-ray Questionnaire: For women only

While we do not offer x-ray services on site, our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ___________________________________ Date of last menstrual period: ___________________

☐ There is a possibility that I may be pregnant at this time. ☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time ☐ I request that x-ray films not be taken because:

______________________________ ____

SIGNATURE (X) **DATE**

FOR MINORS:

I, ____________________________ being the parent or legal guardian of _________________________,
(Print Guardian Name) (Print Minor's Name)
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

______________________________ ____________________________ ______________________

(SIGNATURE) **(PRINTED NAME)** **(DATE)**

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME ______________________________ **DATE** ______________

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ______________________________

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: ______________________________

3. Do your hands or arms fall asleep regularly? NO YES
   Comment: ______________________________

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ______________________________

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ______________________________

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ______________________________

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ______________________________

8. Do your legs or feet fall asleep regularly? NO YES
   Comment: ______________________________

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: ______________________________

10. Do you suffer from cold hands or feet? NO YES
    Comment: ______________________________

11. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication? ______________________________

12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind? ______________________________

13. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for? ______________________________
    ____

14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it? ______________________________
    ____

15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: ______________________________

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

PAIN DISABILITY QUESTIONNAIRE

Patient Name ___________________________________ Date___________________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

Please total your numbers from above here: TOTAL:______/ 150

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. Spine 2004; 29 (20): 2290-2302.

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Consent to Treat: I request and give consent to my physician to provide and perform such medical/ surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties, or guarantees as the results or cures have been made to me or relied upon me.

Consent to Testing: I am fully aware that the physician may order testing that he/she deems appropriate in my treatment. I am aware ProActive Chiropractic & Laser Center plays a large role in verifying insurance benefits on my behalf, and although most testing is verified, it is my responsibility to know my insurance coverage. If I refuse any diagnostic testing/ labs/ urine screening, I understand that the physician has the right to terminate the patient / physician relationship at any time.

H.H.S: Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES is available to me immediately upon request.

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and / or the Medicare program or its intermediaries of carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

Chiropractic Care: The primary focus of chiropractic care is the detection and correction of vertebral subluxation. This is the misalignment of one or multiple spinal bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms.

Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of physical medicine, chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Physical Therapy Burns: Some therapies used in this office generate heat & may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

I have read and I accept the terms above and understand them fully. I hereby give consent to ProActive Chiropractic & Laser Center and Dr. Ryan Friel to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, ____ have read and fully understand the above statements.
(PRINT NAME)

SIGNATURE (X) ________________________________ **DATE** ____________________

Special Financial Information Section

Many insurance companies require physicians to attempt to collect any unpaid portion of the annual deductible and/or co-payment and/or regular treatment fees from the patient. However, certain conditions may permit a physician's office to waive (partially or fully) the collection of these amounts. One of the conditions is the patient's financial hardship. Based upon discussions with me, this office has determined that due to my financial hardship, I am unable to pay (partially or in full) the deductible and/or the co-payment and/or regular treatment fees. If I were forced to pay the annual deductible and/or the co-payment and/or the regular treatment fees, I would not be able to receive the necessary treatment for my health condition(s). Due to these circumstances, this office is waiving (partially or in full) my obligation for payment of charges for the services rendered in this office. However, if based upon future discussions with me regarding my financial situation, this office determines that my situation has improved enough to enable me to fully pay the annual deductible and/or co-payment and/or regular treatment fees, this office will require payment of charges incurred at that time.

______________________ ______________________ ______________________
Name (Print) Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at ProActive Chiropractic & Laser Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. If we are ordered by the courts or another appropriate agency.

In this clinic it is possible to be provided, be billed, and receive records from either PROACTIVE CHIROPRACTIC & LASER CENTER or DR. RYAN FRIEL, DC. I give both entities permission to request records, perform services and bill out for services received by me.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities or would like further information about our privacy policies and practices, you should direct your inquiries to: Dr. Ryan Friel.
This notice is effective as of March 1, 2020. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

________________________ Name (Print)   ________________________ Signature   ________________ Date