CROTHERS CHIROPRACTIC

Today's Date: _____

Patient Name: _____, _____, _____
(Last) (First) (MI)

Address: _____

City: _____State: _____ Zip: _____

☐ Male ☐ Female Birthdate: _____/_____/_____ Age: _____

Home Phone #: (_____)_____ Cell Phone #: (_____)_____

Work Phone#: (_____)_____ Other#: (_____)_____

E-mail Address: _____ Referred By: _____

Employer: _____ Occupation: _____

Status: ☐ Married, Spouse's Name_____ ☐ Partner/Significant Other, Name_____

☐ Widowed ☐ Divorced ☐ Single ☐ Minor, Parent's Name_____

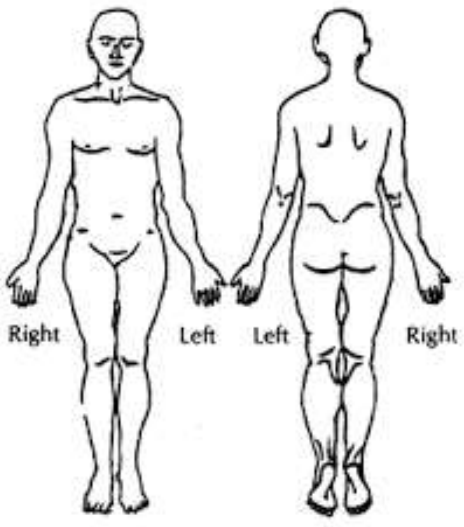
In Case of Emergency Who Should We Contact? _____

Relation: _____ Phone #: (_____)_____

Patient Condition:

My main/most concerning pain is _____.

When Did Your Symptoms Appear? _____



My Condition is Getting Progressively Worse? ☐ Yes ☐ No

My pain is: ☐ Constant ☐ Comes and goes ☐ Daily

Pain level is currently is: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Type Of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling

Does It interfere With Your ☐ Work ☐Sleep ☐ Daily Routine ☐ Recreation

Activities Or Movements That Are Painful To Perform ☐ Sitting ☐ Standing

☐ Walking ☐ Bending ☐ Lying Down ☐ Twisting ☐ Lifting ☐ Other_____

Treatments I have had for my pain: ***(please check all that apply)***

☐ Physical Therapy ☐ Chiropractic Manipulations ☐ Acupuncture ☐ Relaxation Techniques

☐ Epideral Steroid Injections ☐ None ☐ Other _____

Scans I have had for my pain: ***(please check all that apply)***

☐ X-Rays ☐ MRI Scans ☐ CT Scans ☐ EMG/Nerve, conduction studies ☐ None

Personal Medical History: Check all that apply ☐ None apply

Musculoskeletal:
☐ Cerebral Palsy
☐ Fibromyalgia
☐ Gout
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Spina Bifida
☐ Other: _____

Cardiovascular:
☐ Heart Attack
☐ Congestive Heart Failure
☐ High Cholesterol
☐ High Blood Pressure
☐ Other: _____

Gastrointestinal:
☐ Gastric Ulcer
☐ Peptic Ulcer
☐ Hepatitis
☐ Other: _____

Neuro:
☐ Seizure Disorder
☐ Stroke
☐ Other: _____

Vascular / Blood:
☐ Anemia
☐ Blood Clots
☐ Cancer Type _____
☐ DVT (Blood Clot in Leg)
☐ Other: _____

Pulmonary:
☐ Asthma
☐ COPD
☐ Blood Clot in Lung
☐ Emphysema
☐ Sleep Apnea
☐ Other: _____

Renal:
☐ Kidney Stones
☐ Diabetes
☐ Other: _____

Infection:
☐ HIV
☐ Aids
☐ Other: _____

Other Problems:
☐ Eye, Ear, Nose _____
☐ Thyroid _____
☐ GU / Urological _____
☐ Gynecological _____
☐ Orthopaedic Fractures _____
☐ Skin _____
☐ Mental Illness _____

· **Implants (type/location):**
_____
_____
Can you have an MRI with these implants?: · Yes · No

Surgical/Procedure: Previous surgeries – List procedures, surgeon and date ☐ None
_____
_____
_____
_____

Injuries: List any falls, broken bones, dislocations. ☐ None
_____
_____
_____
_____

Allergies: List allergies and reaction ☐ No known allergies
_____
_____
_____
_____

Medications: List current prescription medications ☐ None
_____
_____
_____
_____
_____
_____

Social History:

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Smoking: ☐ Never ☐ Quit, When? _____ ☐ Current, Pack/Day _____

Alcohol: ☐ Never or Rare ☐ Drinks/day _____ ☐ Social

Are you pregnant: ☐ Yes ☐ No Due Date_____

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Patient Consent to the Use and Disclosure of Health Information

For Treatment, Payment and Healthcare Operations

I, _____, understand that as part of my healthcare, Crothers Chiropractic

Clinic originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

1) A basis for planning my care and treatment
2) A means of communication among the many health professionals who contribute to my care
3) A source of information for applying my diagnosis to my bill
4) A means by which a third-party payer can verify that services billed were actually provided
5) A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1) The right to review the notice prior to signing this consent
2) The right to object to the use of my health information for directory purposes
3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Crothers Chiropractic Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Crothers Chiropractic Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Crothers Chiropractic Clinic change their notice they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via Fax.

I understand and accept/decline the terms of this consent.

Patient's Signature: _____ Date: _____

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Dr. Robert A. Crothers

PATIENT RIGHTS AND RESPONSIBILITIES

While you are a patient of Crothers Chiropractic, we will do our best to protect and promote your personal rights in accordance with all relevant state and federal laws, and Joint Commission Accreditation of Healthcare Organization standards. For additional information about your rights, you may contact our Patient Advocate at (309) 274-9400.

ACCESS TO CARE.
YOU/YOUR REPRESENTATIVE'S RIGHTS INCLUDE:

1. Access to medical care regardless of race, creed, sex, disability, national origin or source of payment.
2. Have his or her cultural, psychosocial, spiritual and personal values, beliefs, and preferences respected.
3. A medical screening examination and stabilizing care, regardless of ability to pay.
4. A consultation or second opinion from another physician as well as to change physicians.
5. Examination and receive a reasonable explanation of your medical bill.
6. Accommodation of any special needs or disabilities including provision of interpretive assistance or assistive devices.

RESPECT/DIGNITY/CONFIDENTIALITY/SAFETY.
YOU/YOUR REPRESENTATIVES'S RIGHTS INCLUDE:

1. Considerate care that safeguards your dignity and respects your cultural, psychosocial, and spiritual values.
2. Confidentiality of your medical records and information.
3. Care in a safe and secure setting.
4. Protection from all forms of abuse or harassment.
5. Access protective services, including counseling or guardianship, and to reach the maximum level of Independence.
6. Access to pastoral care upon request.
7. The identity and profession of all those providing patient care services.

INVOLVEMENT IN CARE/INFORMED CONSENT/RESEARCH.
YOU/YOUR REPRESENTQATIVE'S RIGHTS INCLUDE:

1. Access to all information concerning your medical condition, treatment, prognosis and other treatment available and to choose among these alternatives.
2. Participation in ethical questions that arise in the course of your care.
3. Making informed decisions regarding your care. This right includes being informed of your health status, being involved in care planning and treatment, and being able to request and refuse treatment and to know what may happen if you don't have this treatment.
4. To address end of live decisions with their provider upon their request and as deemed appropriate.
5. Designating a decision-maker if incapable of understanding a proposed treatment or if unable to communicate your wishes regarding care.
6. Participate in research studies after giving informed consent.
7. Participate in the development and implementation of your plan of care.
8. Pain management support.
9. Access to your medical record or you may request a copy of your medical record.

COMPLAINT/GRIEVANCE PROCEDURE
YOU/YOUR REPRESENTATIVE'S RIGHTS INCLUDE:

1. Discussion of any concerns/dissatisfaction with the care received, which cannot be resolved by available staff, by contacting the Pride Line at (309) 671-8209 or ask any staff member to contact them on your behalf.
2. Response to Pride Line calls on the same day that the call is received, even if further investigationof the concerns/dissatisfaction is required.
3. You may also contact the Illinois Department of Public Health's Central Complaint Registry at 1-800-252-4343 or writing them at Illinois Department of Public Health, Office of Health Care Regulation, 525 W. Jefferson Street, 5th Floor, Springfield, IL 62761-0001.
4. You may also contact, in writing, Division of Accreditation and Certification Operations, Office of Quality Monitoring, Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181; Fax: 630-792-5005; E-Mail: complaint@jointcommission.org, or call 1-800-994-6610.

COMMUNITY CARE PROGRAM

You may be eligible for financial assistance under the terms and conditions the clinic offers to qualified patients. For more information, contact 1-800-845-0231

PATIENT RESPONSIBILITIES

The patient and/or, when appropriate, family is responsible for:

1. Providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives and other matters relating to the patient's health.
2. Reporting unexpected changes in the patient's condition to the responsible practioner and whether the patient clearly comprehends a contemplated course of action and what is expected of him or her.
3. Following the treatment plan developed with the practitioner. The patient should express any concerns regarding his or her ability to comply with a proposed course of treatment, and every effort should be made to adapt the treatment plan to the patient's specific needs and limitations.
4. His/her actions if he/she refuses treatment or does not follow his/her practitioner's instructions.
5. Assuring that all of their financial obligations for his/her care are fulfilled.
6. Following all Crothers Chiropractic rules and regulations affecting the patient care, conduct and safety.
7. Consideration of the rights of other patients and Crothers Chiropractic personnel.