

Chiropractic Associates of Kankakee, Inc.

Dr. Brent W. Adams, Chiropractor

53 N. Main St., Manteno IL 60950

(815) 468-7787

232 N Industrial Dr., Bradley IL 60915

(815) 614-3073

Staff use

Account # _____

Date: _____

Confidential Patient Questionnaire

→ PLEASE NOTIFY US IF CONDITION IS DUE TO WORK OR ACCIDENT ←

PERSONAL DATA

| | | |
|--|--|---|
| Patient Name: <i>(Last, First, M.I.):</i> | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Called Name: | Date of Birth: | Age: |
| Address: <i>(Street):</i> | Marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W | |
| <i>(City, State, ZIP):</i> | How Many Children: | |
| Home phone: | Work phone: | |
| Cell phone: | Emergency name and #: | |
| Employer Name: | Occupation: | |
| Email: | Referred by: | |

CONTRACT FOR SERVICES

Print Patient Name: _____

By signing below:

- I understand that I am responsible for all fees for services performed in this office, and I agree to pay all fees for services provided to me at the time of visit. I understand that any insurance benefits, which I have, are a contracted arrangement between that insurance company and me. This office will be responsible for preparing notes, billing receipts, and informational reports as needed to aid in insurance payment/reimbursement. This office is required by law to file all Medicare claims for its patients.
- I understand and agree to the terms of this contract for professional services with Chiropractic Associates of Kankakee and I consent to diagnosis and treatment. I realize there is no guarantee of results, and have been informed that some risks of treatment do exist. While I do expect my doctor to use his/her best judgment to choose the most appropriate care for my condition. I agree that the doctor cannot foresee every possible complication/risk, which could arise in my treatment.
- (For **Females only**) To the best of my knowledge I am **Pregnant** or **Not Pregnant (please circle one)**.
- I hereby give permission to the Doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I authorize insurance benefits to be paid directly to Chiropractic Associates of Kankakee.
- Under the Health Insurance Portability and Accountability Act (HIPAA), I authorize the release of any information necessary to process my insurance or other benefits.
- I give the physicians and staff of Chiropractic Associates of Kankakee, Inc. permission to treat the minor child that I have guardianship of and will abide by the above stated contract for services rendered to the above mentioned minor child.

Signature of Person Responsible for Payment: _____ **Date:** _____

For Minor: Guardian Signature _____ **Date:** _____

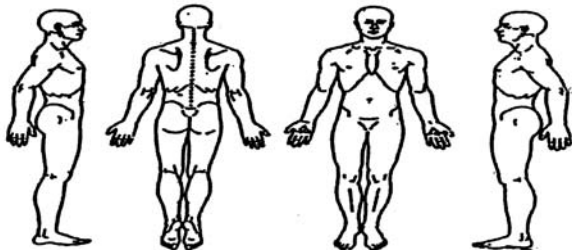
Witness: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Age _____
Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

