

**Chiropractic Associates of Kankakee, Inc.**

**Dr. Brent W. Adams, Chiropractor**  
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: \_\_\_\_\_

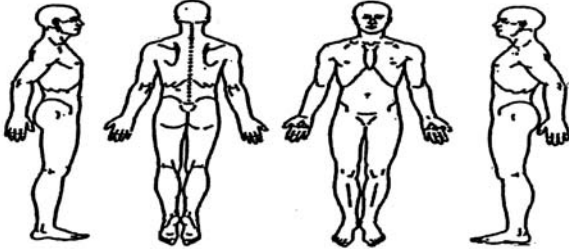
Witness: \_\_\_\_\_

# 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

**18. Indicate if you have any immediate family members with any of the following:**

- |   |                                   |                                |
|---|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Cancer   | <input type="checkbox"/> ALS   |

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		<b>For Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**20. List all prescription medications you are currently taking:**

\_\_\_\_\_

**21. List all of the over-the-counter medications you are currently taking:**

\_\_\_\_\_

**22. List all surgical procedures you have had:**

\_\_\_\_\_

**23. What activities do you do at work?**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

**24. What activities do you do outside of work?**

\_\_\_\_\_

**25. Have you ever been hospitalized?**  No  Yes

if yes, why \_\_\_\_\_

**26. Have you had significant past trauma?**  No  Yes

**27. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_