DR. ALEX PARK, D.C.

831 W. TOUHY AVE
PARK RIDGE, IL 60068

PLEASE FILL OUT THE FOLLOWING INFORMATION TO THE BEST OF YOUR ABILITY:

FIRST NAME:______________________________ LAST NAME:______________________________ DATE:________________

CURRENT ADDRESS:_____________________________ CITY:_____________________ STATE:________ ZIP:____________

TELEPHONE (CELL): ____________________ (HOME):_____________________ E-MAIL:______________________________

BIRTH DATE:_______________ SEX:____ OCCUPATION:_________________________ EMPLOYER:___________________

EMERGENCY CONTACT:____________________________ PHONE:__________________ RELATION:____________________

HOW DID YOU HEAR ABOUT US?____

FAMILY DOCTOR:______________________ ADDRESS:____________________________________ PHONE:_______________

DATE LAST SEEN:___________ WHAT WERE YOU SEEN FOR:____________________ OUTCOME:____________________

REFERRING DOCTOR:_________________ ADDRESS:____________________________________ PHONE:________________

PRIMARY INSURANCE INFO:

POLICY HOLDER'S NAME:__________________________________ RELATIONSHIP TO PATIENT:______________________

POLICY HOLDER'S DATE OF BIRTH:______________ NAME OF INSURANCE COMPANY:___________________________

IF IN AUTO ACCIDENT/WORK COMP. INJURY, PLEASE PROVIDE:

NAME OF INSURANCE COMPANY:_________________________________ CONTACT PERSON:________________________

PHONE NUMBER:____________________ CLAIM NUMBER:_____________________ DATE OF ACCIDENT:_____________

SECONDARY INSURANCE INFO (IF APPLICABLE):

POLICY HOLDER'S NAME:__________________________________ RELATIONSHIP TO PATIENT:______________________

POLICY HOLDER'S DATE OF BIRTH:______________ NAME OF INSURANCE COMPANY:___________________________

RELEASE OF INFORMATION

I AUTHORIZE PARK RIDGE SPINE AND SPORTS MEDICINE AND ITS STAFF TO RELEASE TO THE ABOVE COMPANY(IES) OR ITS REPRESENTATIVES, TO MYSELF, TO MY PRIMARY CARE PHYSICIAN OR REFERRING PHYSICIAN ANY INFORMATION USED FOR TREATMENT AND PAYMENT.

ASSIGNMENT OF BENEFITS

I UNDERSTAND AND AGREE THAT HEALTH/ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND AND AGREE THAT ALL SERVICES REDERED TO ME AND CHARGED ARE MY PERSONAL RESPONSIBILITY FOR TIMELY PAYMENT. I UNDERSTAND IF I TERMINATE MY CARE/TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

CONSENT TO TREATMENT

I ____________________________ (PRINT NAME) KNOWING THAT I HAVE A CONDITION REQUIRING DIAGNOSIS AND TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO DIAGNOSTIC EXAMINATION PROCEDURES AND TREATMENT BY DR. ALEX PARK, D.C.

SIGNATURE:____ DATE:_______________

(SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN IF PATIENT IS UNDER 18)

PARK RIDGE SPINE AND SPORTS MEDICINE: MEDICAL HISTORY

CURRENT COMPLAINTS:

DATE CURRENT SYMPTOMS BEGAN:_________________

PLEASE GIVE A BRIEF DESCRIPTION OF HOW THE SYMPTOMS BEGAN:

____

____

____

____

____

HAVE YOU EVER HAD THE SAME CONDITION? ____YES ____NO IF YES, WHEN?___________________________

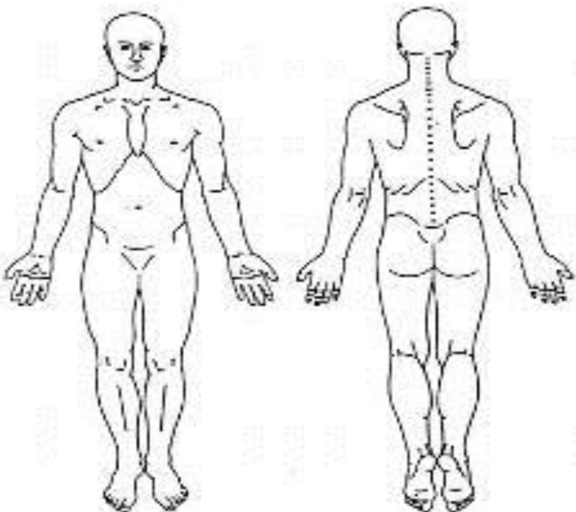
HAVE YOU SEEN ANY OTHER PRACTIONERS FOR YOUR CURRENT COMPLAINT? ____YES ____NO

IF YES, WHO AND PLEASE DESCRIBE:____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? ____YES ____NO

IF YES, PLEASE DESCRIBE/WHEN?____

USE THE DIAGRAM BELOW TO INDICATE WHERE YOUR PAIN IS LOCATED:



USE SYMBOLS TO DESCRIBE YOUR PAIN:

- BURNING = XXXX
- SHARP = \\\\\
- NUMB = NNNN
- DEEP/DULL ACHE = DDDD
- PINS/NEEDLES = OOOO
- STIFFNESS = SSSS
- OTHER (PLEASE SPECIFY):

PLACE AN “X” ON THE LINE BELOW INDICATING YOUR LEVEL OF PAIN:

NO PAIN ____ WORST PAIN IMAGINABLE

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?____

WHAT MAKES YOUR PROBLEM WORSE?____

WHAT MAKES YOUR PROBLEM BETTER?____

DOES THE PAIN RADIATE ANYWHERE?____YES ____NO IF YES, WHERE TO?_________________________

DOES YOUR PROBLEM WAKE YOU UP AT NIGHT?____YES ____NO

WHAT TIME OF DAY ARE YOUR SYMPTOMS WORSE (IE MORNING, AFTERNOON, ETC)?_______________________

HAS THIS PROBLEM INTERFERRED WITH YOUR WORK AND DAILY ACTIVIES (CHECK ALL THE APPLY)?

____NOT AT ALL ____A LITTE ____MODERATELY ____QUITE A BIT ____EXTREMELY

PLEASE EXPLAIN:____

DID YOU RECEIVE ANY DIAGNOSTIC IMAGING?

____XRAY ____MRI ____CT ____OTHER:______________ DATE TAKEN?_________________

SIGNATURE:____ DATE:_______________

(SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN IF PATIENT IS UNDER 18)

PARK RIDGE SPINE AND SPORTS MEDICINE: MEDICAL HISTORY

PAST MEDICAL HISTORY:

PLEASE LIST ALL MEDICATIONS/VITAMINS/SUPPLEMENTS YOU CURRENTLY TAKE:

____

____

PLEASE LIST ALL REASONS YOU MAY HAVE BEEN HOSPITALIZED IN THE PAST:

____

____

PLEASE LIST ALL CURRENT AND PAST MEDICAL CONDITIONS:

____

____

PLEASE LIST ALL SURGICAL PROCEDURES AND MAJOR TRAUMA (IE, BROKEN BONES) YOU HAVE HAD:

____

____

PLEASE LIST ALL PAST AND PRESENT HEALTH CONDITIONS OF PRIMARY FAMILY MEMBERS (IE, HEART DISEASE, DIABETES, CANCER, ARTHRITIS, ALS, LUPUS):

____

____

DO YOU SMOKE?____YES ____NO IF YES, HOW MANY CIGARETTES PER DAY?______________________________

HOW WOULD YOU DESCRIBE YOUR ALCOHOL INTAKE (CIRCLE ONE): NONE LIGHT MODERATE HEAVY

PLEASE CIRCLE ANY OF THE FOLLOWING IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE CONDITIONS LISTED (AND USE A "C" FOR A CURRENT PROBLEM AND A "P" FOR A PAST PROBLEM):

ALLERGIES	ANEMIA	ARTHRITIS	BACK PAIN
BREAST LUMP	CANCER	CHEST PAIN	DIFFICULTY BREATHING
HEADACHES	RHEUMATOID ARTHRITIS	HIGH BLOOD PRESSURE	STROKE
ANGINA	PROSTATE PROBLEMS	DIABETES	HIGH CHOLESTEROL
KIDNEY STONES	KIDNEY INFECTION	DIARRHEA/CONSTIPATION	HEMORRHOIDS
IRREGULAR HEART BEAT	PACEMAKER	DIGESTIVE PROBLEMS	NUMBNESS/TINGLINNG
ULCER	LOSS OF BOWELL CONTROL	LOSS OF BLADDER CONTROL	NUEROLOGIC DISORDER
MENTAL DISEASE	DEPRESSION	DERMATITIS/ECZEMA/RASH	LIVER DISORDER
VOMITTING	SCOLIOSIS	SCIATICA	SWELLING OF JOINTS
BRUISE EASILY	NERVOUSNESS	THYROID CONDITION	EAR RINGING
VENEREAL DISEASE	EYE PAIN/DIFFICULTIES	OTHER:	OTHER:

PLEASE EXPLAIN ANY OF THE ABOVE IF YOU HAVEN'T DONE SO ALREADY:

____

____

FOR FEMALES ONLY: DO YOU HAVE MENSTRUAL PROBLEMS?____YES____NO

DO YOU TAKE BIRTH CONTROL?____YES____NO

IS THERE A CHANCE YOU ARE CURRENTLY PREGNANT?____YES____NO

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US OR THINK WE SHOULD KNOW?

____

____

SIGNATURE:____ DATE:_______________

(SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN IF PATIENT IS UNDER 18)