



**Park Ridge Spine & Sports
Medicine**

36 Main Street, Suite 100
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 RENDERED 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? _____

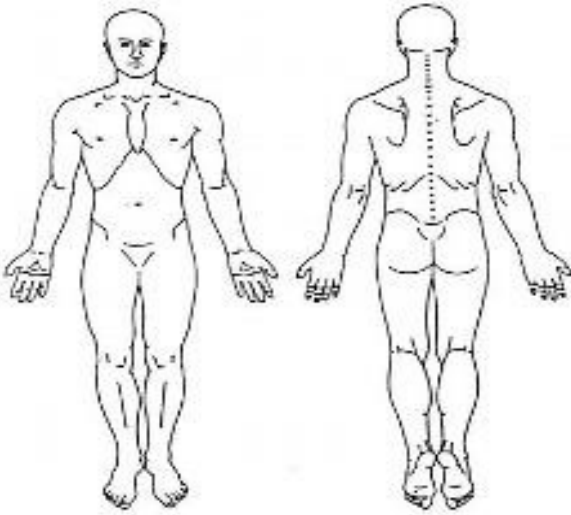
HAVE YOU SEEN ANY OTHER PRACTITIONERS FOR YOUR CURRENT COMPLAINT? ___ YES ___ NO

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 ACTIVITIES (CHECK ALL THAT APPLY)?

___ NOT AT ALL ___ A LITTLE ___ MODERATELY ___ QUITE A BIT ___ EXTREMELY

PLEASE EXPLAIN: _____

DID YOU RECEIVE ANY DIAGNOSTIC IMAGING?

___ XRAY ___ MRI ___ CT ___ OTHER: _____

DATE TAKEN? _____

SIGNATURE: _____ DATE: _____

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/TINGLING
ULCER	LOSS OF BOWEL CONTROL	LOSS OF BLADDER CONTROL	NEUROLOGIC 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

SIGNATURE: _____ DATE: _____