

WELCOME TO SPINE INSTITUTE OF WAUKEGAN

Five Standards for New Patients

1.	All new patients are required to fill out a personal health questionnaire. Some items on the first page will have to be written down a second time.
2.	You will have a personal consultation with the doctor to discuss your intake form and health problems.
3.	The doctor will perform diagnostic chiropractic, orthopedic, and neurological examination procedures.
4.	You will be advised if there is a need for additional procedures such as X-rays, MRI, or CT Scan.
5.	You will have a personal discussion with the doctor to discuss your care plan and treatment.

Confidential Patient Information

Name		Date
Address		City/State/Zip Code
Home Phone ()	Work Phone ()	Cell Phone/Pager ()
Email Address	Date of Birth	Current Age

Work Status: Employed Retired Disabled Full-time Student Part-time Student

Employer	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

Marital Status: Married Single Divorced Widow Spouse's Name _____

Whom may we thank for referring you? _____

FEMALES ONLY – IN REFERENCE TO RADIOGRAPHIC IMAGING

I, _____, to the best of my knowledge confirm that I am not pregnant, and waive all responsibility to the Doctor.	
Signature:	Date:

MINORS ONLY – CONSENT FOR TREATMENT

I hereby authorize Dr. Kelly G. Worth and whomever she may so designate as her assistant, to administer chiropractic care as he deems necessary to my son/daughter, _____, dated at Waukegan, IL this _____ day of _____, 20____.	
Signature:	Witnessed:

ALL PATIENTS – IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:		
Home Phone ()	Work Phone ()	Cell Phone ()

NEW PATIENT CHECKLIST PAGE 2

Please list your major ailments in order of severity (from most debilitating to least debilitating):

1.	4.
2.	5.
3.	6.

Primary Ailment - _____

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms Spread? <input type="checkbox"/> No <input type="checkbox"/> Yes. Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant (100% of day) <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Is your pain <input type="checkbox"/> Deep or <input type="checkbox"/> Superficial
Please indicate the character of your pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Knife-like Throbbing
Are you experiencing any of the following associated symptoms? <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __ Sitting for __ min., __ Standing, __ Walking, __ Lying, __ Pushing, __ Pulling, __ Lifting __ lbs., __ Gripping Hot/Cold, __ Coughing/sneezing, __ Bowel Movements, __ Mental Activities, __ Bright lights, __ Other _____, __ Other _____, __ Other _____
Please indicate what helps to alleviate the pain. <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Medications _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.)

Please include any other relevant history in regards to this ailment.

NEW PATIENT CHECKLIST PAGE 3

Additional Ailment - _____

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms Spread? <input type="checkbox"/> No <input type="checkbox"/> Yes. Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant (100% of day) <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Is your pain <input type="checkbox"/> Deep or <input type="checkbox"/> Superficial
Please indicate the character of your pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Knife-like Throbbing
Are you experiencing any of the following associated symptoms? <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __ Sitting for __ min., __ Standing, __ Walking, __ Lying, __ Pushing, __ Pulling, __ Lifting __ lbs., __ Gripping Hot/Cold, __ Coughing/sneezing, __ Bowel Movements, __ Mental Activities, __ Bright lights, __ Other _____, __ Other _____, __ Other _____
Please indicate what helps to alleviate the pain. <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Medications _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.)

Please include any other relevant history in regards to this ailment.

IF YOU HAVE MORE THAN TWO AILMENTS, PLEASE ASK THE RECEPTIONIST FOR ADDITIONAL "AILMENT" FORMS.

NEW PATIENT CHECKLIST PAGE 4

Past Medical History

Please include any of your previous conditions.

If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls or Traumas: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:

Motor Vehicle Accidents: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:
Work Injuries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:

Females Only - Menopausal Symptoms: <input type="checkbox"/> None <input type="checkbox"/> Yes Explain:

Habits

Cigarettes/Cigars	<input type="checkbox"/> None <input type="checkbox"/> Yes How much per week?
Alcohol	<input type="checkbox"/> None <input type="checkbox"/> Yes How many drinks per week? What type of Alcohol?
Coffee	<input type="checkbox"/> None <input type="checkbox"/> Yes How many cups per week?
Exercise	<input type="checkbox"/> None <input type="checkbox"/> Yes Hours/Days per week? Types?
Water	<input type="checkbox"/> None <input type="checkbox"/> Yes Glasses per day?
Soft Drinks	<input type="checkbox"/> None <input type="checkbox"/> Yes Amount per week? Types?
Sleep	<input type="checkbox"/> None <input type="checkbox"/> Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desired per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?

<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological Disorders _____ <input type="checkbox"/> Autoimmune Disorders _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Other _____

NEW PATIENT CHECKLIST PAGE 5

Personal Health History

Medications: Please list your current medications, how long you have been taking them and for what they are taken.
Vitamins and Minerals: Please list your current supplements.

Check the left box for any condition YOU had in the PAST, and the right box for any condition YOU have CURRENTLY.

GENERAL HEALTH HISTORY

P	C	P	C	P	C	P	C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorders		Diabetes		Pneumonia		Infective Disease	
Epilepsy		Anemia		Tuberculosis		Fungal Infection	
Tumors		Glaucoma		Hepatitis		Herpes	
Alcoholism		Heart Disease		Thyroid Disease		Arthritis	
Drug Addiction		Rheumatic Fever		Parasites		Autoimmune Disease	
Cancer		Scarlet Fever		Asthma		Chicken Pox	

<u>NERVOUS SYSTEM</u>		<u>EYES/EARS/NOSE/THROAT</u>		<u>GASTROINTESTINAL</u>		<u>MUSCULOSKELETAL</u>	
P	C	P	C	P	C	P	C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression		Vision Problems		Poor/Excess Appetite		Jaw Pain	
Memory Loss		Flashing Lights		Excessive Thirst		Difficulty Chewing	
Confusion		Black Spots		Frequent Nausea		Face Pain	
Dizziness		Blurriness		Hemorrhoids		Neck Pain	
Fainting		Hearing Loss		Black/Bloody Stools		Arm/Elbow Pain	
Convulsions		Ringing in Ears		Digestive Problems		Wrist/Hand Pain	
Weakness		Swallowing Difficulty		Abdominal Cramping		Mid Back Pain	
Poor Balance				Gas/Bloating		Lower Back Pain	
Twitches/Tremor				Heartburn		Thigh/Knee Pain	
Cold/Tingle Extremities				Weight Problems		Ankle/Foot Pain	
Sleeping Difficulties				Gall Bladder Problems		Difficulty Walking	
Headaches				Liver Problems		Leg/Arm Fatigue	

<u>CARDIOVASCULAR</u>		<u>REPRODUCTIVE</u>		<u>GENITOURINARY</u>	
P	C	P	C	P	C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain		Erectile Difficulties		Bladder Trouble	
Irregular Heartbeat		Sexual Dysfunction		Painful Urination	
High Blood Pressure		Menstrual Irregularity		Incontinence	
Shortness of Breath		Menstrual Cramping		Discolored Urine	
Lung/Congestion Problems		Venereal Infection			
Varicose Veins					
Ankle Swelling					

How many times per day do you urinate?	How often do you have a bowel movement?
Do you experience any <input type="checkbox"/> urgency, <input type="checkbox"/> dribbling, or <input type="checkbox"/> incontinence?	Do your stools <input type="checkbox"/> Float or <input type="checkbox"/> Sink?
Is this urination pattern consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your bowel movements consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No

CONFIDENTIALITY

In the event this office needs to contact you:

May we leave a message for you with someone at your home phone number? Yes No

May we leave a message for you on your home answering machine? Yes No

May we leave a message for you with someone at your work phone number? Yes No

May we fax information that you request? Yes No

Agreement for Payment of Services (Please initial all that apply)

_____ I understand that Spine Institute of Waukegan is not familiar with my Blue Cross/Blue Shield or Health Select health insurance policy, nor can they determine whether my insurance will pay for all or part of the services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ I acknowledge and agree that I will be personally responsible for all the payments for Spine Institute of Waukegan services, whether or not my insurance pays for all or part of the services.

_____ I acknowledge that I have no other insurance coverage.

Patient Signature

Date