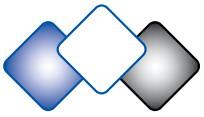
WELCOME!



QUALITY CARE CHIROPRACTIC

Dr. Jennifer Gross, D.C.
Dr. Rick Gross, D.C.

Name						Date
Address						
City			State			Zip
Date of Birth		Age		Social Security Number		
☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed	Sex	☐ Male ☐ Female
E-mail Address:						
Home Phone:						
Work Phone:						
Cell Phone:		☐ Texting is OK		Circle Service Provider: Verizon, AT&T, Tmobile, Sprint Other:_____		
In case of emergency, please contact: Name:				Relationship: Phone:		

Occupation				
Employer Name/Company				
Address				
City	State	Zip		Phone
Spouse's Name				Date
Address (if different)				
City		State		Zip
Date of Birth	Age	Social Security Number		
Spouse's Occupation				
Employer Name/Company				
Address				
City	State	Zip		Phone
Names and Ages of your children:				

What prompted you to choose us:
☐ Insurance network ☐ Advertisement/ Promotion ☐ Personal referral
☐ Driving/walking by ☐ Phone book listing ☐ Other _____

Reason for your visit or area of concern:

When did your symptoms begin?

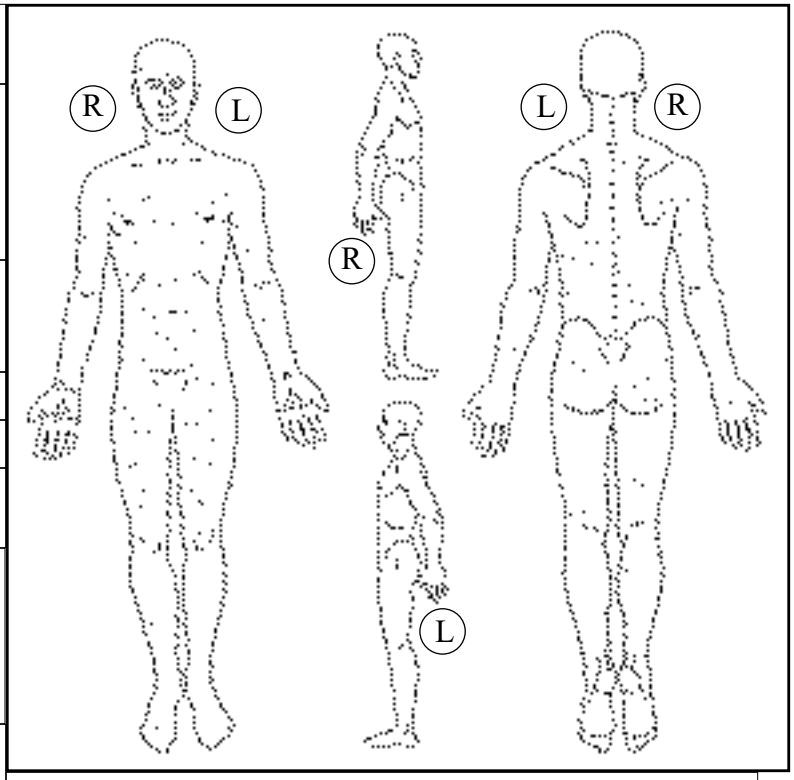
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unsure

Please put an X on the line below indicating your pain at its *worst*:
No Pain ——————————————— Severe Pain

Please put an X on the line below indicating your pain at its *best*:
No Pain ——————————————— Severe Pain

Please put an X on the line below indicating your pain level *at this time*:
No Pain ——————————————— Severe Pain

Use the bolded letters below on the body diagram to indicate where you are experiencing those symptoms.



Type of pain:

- ☐ **S**harp
- ☐ Shooting (**O**)
- ☐ **T**hrobbing
- ☐ **A**ching
- ☐ **B**urning
- ☐ **C**ramping
- ☐ Stiffness (**F**)
- ☐ Soreness(**R**)
- ☐ Tingling (**G**)
- ☐ Swelling/**P**ressure
- ☐ **N**umb (no feeling)
- ☐ **D**ull

How often do you have these symptoms?

- ☐ 0-25% of awake time
- ☐ 51-75% of awake time
- ☐ 26-50% of awake time
- ☐ 76-100% of awake time

How many times does it occur in a day?

How many times does it occur in a week?

Activities the condition interferes with:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What have you already tried to relieve your symptoms:

Please list your Primary Care Physician, as well as any other physicians seen for this condition:
PCP:
Other:

Women only:
Are you pregnant? ☐ Yes ☐ No ☐ Unsure, or Possibly

Date of last:
Physical Exam: _____ Visit to a Chiropractor: _____ Spinal X-ray: _____
Chest X-ray: _____ Dental X-ray: _____ MRI /CT /Bone Scan: _____
Blood test: _____ Urine test: _____

Previous injuries, traumas, surgeries, hospitalizations (include description and dates):

Current medications (include name, dosage, and reason for taking):

Vitamins, supplements:

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Exercise Level: ☐ None ☐ Light ☐ Moderate ☐ Heavy/Intense

Habits:

- ☐ Smoking — Packs/day _____ Years smoking _____
- ☐ Alcohol consumption — Drinks/week _____
- ☐ Coffee / caffeine drinks — Cups or drinks per day _____

Known allergies:

Average Stress Level: ☐ Low ☐ Moderate ☐ High Due to:

Health History

QUALITY CARE CHIROPRACTIC

Name	Date

	Previously had	Currently have
AIDS/HIV	☐	☐
Severe/Constant Chills	☐	☐
Severe Fatigue	☐	☐
Significant Fever	☐	☐
Loss of sleep	☐	☐
Noticeable weight loss	☐	☐
Noticeable weight gain	☐	☐
Depression	☐	☐
Bleeding disorders	☐	☐
Cancer	☐	☐
Chemical or substance dependency/abuse	☐	☐
Diabetes	☐	☐
Hernia	☐	☐
Psychiatric care	☐	☐
Stroke	☐	☐
Tumors	☐	☐
Night sweats	☐	☐
Thyroid problems	☐	☐
Hearing difficulty	☐	☐
Dental problems	☐	☐
Ear ache	☐	☐
Ringing in the ears	☐	☐
Ear discharge	☐	☐
Sinus trouble	☐	☐
Nosebleeds (frequent)	☐	☐
Poor vision	☐	☐
Hoarseness	☐	☐
Eye pain	☐	☐
Arthritis	☐	☐
Fractures	☐	☐
Herniated disc	☐	☐
Osteoporosis	☐	☐
Pinched nerve	☐	☐
Foot trouble	☐	☐
Low back pain	☐	☐
Neck stiffness/pain	☐	☐
Shoulder pain	☐	☐
Pain/numbness in joints/arms/legs	☐	☐
Swollen joints	☐	☐
Muscle aches/ soreness	☐	☐
Postural difficulties	☐	☐
Sciatica	☐	☐
Scoliosis/curvature	☐	☐
Bedwetting	☐	☐
Blood in urine	☐	☐
Frequent urination	☐	☐
Urgent urination	☐	☐
Painful urination	☐	☐

	Previously had	Currently have
Difficulty starting/ stopping flow	☐	☐
Getting up at night to urinate (>3x/night)	☐	☐
Inability to control bladder	☐	☐
Kidney infection/ stones	☐	☐
Sexual difficulties	☐	☐
Heart disease	☐	☐
High cholesterol	☐	☐
Pacemaker	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Pain over heart	☐	☐
Poor circulation	☐	☐
Irregular heart beat	☐	☐
Varicose veins	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Chest pain	☐	☐
Cough	☐	☐
Spitting up blood or phlegm	☐	☐
Wheezing	☐	☐
Eating disorder	☐	☐
Hepatitis	☐	☐
Liver disease	☐	☐
Ulcers	☐	☐
Acid reflux/ GERD	☐	☐
Belching/gas	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Poor digestion	☐	☐
Poor appetite	☐	☐
Bloating	☐	☐
Excessive hunger	☐	☐
Excessive thirst	☐	☐
Jaundice	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Pain over stomach	☐	☐
Black/bloody stool	☐	☐
Gall bladder problem	☐	☐
Itching	☐	☐
Bruising easily	☐	☐
Change in moles	☐	☐
Skin cancer	☐	☐

	Previously had	Currently have
Headaches	☐	☐
Multiple sclerosis	☐	☐
Numbness/tingling	☐	☐
Tremors	☐	☐
Weakness	☐	☐
Twitching	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Convulsions/Epilepsy/ Seizures	☐	☐
Men		
Prostate problem	☐	☐
Testicular swelling/ pain	☐	☐
Women		
Breast lump/pain	☐	☐
Miscarriage	☐	☐
Vaginal infections	☐	☐
Painful periods	☐	☐
Excessive flow	☐	☐
Irregular cycles	☐	☐
Vaginal burning	☐	☐
Hot flashes	☐	☐
Date last period began	___/___/___	

Family History

Are there family members that we can help? List which of your relatives have the following conditions. Choose from the following: mother, father, brother, sister, grandmother, grandfather, son or daughter.

Back pain _____

Neck pain _____

Headaches _____

Diabetes _____

Heart disease _____

High blood pressure _____

High cholesterol _____

Cancer _____

Muscle/bone/nerve disease _____

Other (specify condition)

_____

_____

Quality Care Chiropractic Clinic, Ltd.
2460 S. Eola Road, Suite G
Aurora, IL 60503
(630) 499-2225

QUALITY CARE CHIROPRACTIC

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GOALS

Patient name: _____ Date: _____

What is difficult for you to do now, that you were able to do before, or that you want to do?
(tying shoes, bending forward to pick up something off the ground, reach into car to put kid into car seat, change positions at night while sleeping, pain while walking with each step, etc.)

What do you like to do?
(golf, yardwork, treadmill, weights, swim, run, play with kids, knit, etc.)

How much of it can you do now (today or this week)?
(as much as I want, only 15 minutes before taking a break, 5 minutes before pain starts, etc.)

How much of it could you do before (last week, last month, etc.)?

How much do you want to do?
(all day, 4 hours of driving with 1-2 breaks, 18 holes of golf, be able to get of floor without assistance, etc.)

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QUALITY CARE CHIROPRACTIC

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Dr. Rick Gross, D.C.

Payment policy (Office Copy)

(Patient copy available upon request)

Your treatment plan and any therapies used are based on medical necessity, not on your insurance coverage or your ability to pay. If you are concerned about Quality Care Chiropractic Clinic's fees for any therapies, please notify the doctor or office manager immediately. As a patient, you do have the right to refuse any of the recommended therapies for your own personal reasons.

INSURANCE

Payment will be due by you at the time of service for any non-covered services, deductibles, or co-pays. If you have a deductible that has not been met, we will collect the full amount of fees for services provided on each visit, up to your deductible amount. Any fees collected exceeding the amount you are responsible for will be applied to future visits, credited to your account, or refunded upon request when there are no outstanding balances on your account.

Your insurance policy is a contract between you and your insurance company. Quality Care Chiropractic Clinic has no authority over your benefits or coverage. While Quality Care Chiropractic Clinic does its best to work with your insurance company, the benefits quoted to us by your insurance company are not a guarantee of payment, and you are ultimately responsible for all fees for services provided. If your insurance denies payment for services you have received, you will be required to pay for those services in full.

"CASH" or SELF-PAY

If your insurance cannot be verified at the time of service, you do not have insurance or your insurance policy does not cover our services, then all fees must be paid in full, with applicable time-of-service discount. If you pay for all services rendered on the day that they are performed (time-of-service), then you are entitled to a reduction in the fees. If you pay at a later date, the reduced rate does not apply.

You are responsible for paying your entire account balance, according to the terms listed above, regardless of perceived value, effectiveness of therapy, or expected outcomes.

If you are the guantor, parent or guardian of a minor being treated by Quality Care Chiropractic Clinic or its physicians, you hereby acknowledge that you are solely responsible for the payment of all bills incurred in the treatment of your minor child.

If financial hardship can be verified, we can establish a payment plan.

When you receive a statement for payment due, the due date will be printed on the statement. Quality Care Chiropractic Clinic must receive payment by the due date. If no payment is received after two notices, your account may be turned over to our collection agency, and any unpaid balances can be reported to the credit bureau which would be reflected on your credit report as a delinquent account.

If you have any amount that is "Past Due" on your account, any new balances will also be considered due immediately with no grace period for payment. In the event Quality Care Chiropractic Clinic undertakes any type of legal action to collect unpaid balances, you understand that you are obligated to pay any and all court costs and reasonable attorney fees incurred by Quality Care Chiropractic Clinic.

The contact information you have provided on the intake form will be used to notify you. The address you provide is where Quality Care Chiropractic Clinic will send all correspondence. The phone numbers provided will be where Quality Care Chiropractic Clinic will call to notify you. If this information changes you are responsible for notifying Quality Care Chiropractic Clinic immediately to prevent any miscommunications.

I have read and understand all of the information contained in this payment policy. All of my questions have been answered to my satisfaction. To the best of my knowledge, the information I have provided is true and accurate. I understand that I am ultimately responsible for paying for any services that I receive from Quality Care Chiropractic Clinic and its employees.

Signature: _____ Date: _____

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QUALITY CARE CHIROPRACTIC

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)