330 S. Main St. Ste E

Morton Il 61550

309-321-8377

ABOUT YOU

Name: ______________________ Today's Date: ____________ File #: ________

Preferred to be Called: ______________ Birthdate: ______________________ Age: ________

Mailing Address: ______________ City: ____________ State: ________ Zip: ________

Phone: ______________________ Email: ______________________

Employer: ______________________ Occupation: ______________ Duration: ________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

How did you hear about us? ______________________

REASON FOR VISIT

When did condition begin: ______________________

Please describe the pain & its location: ______________________

What caused your pain ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic ☐ Other ______________

Explain what happened: ______________________

What makes the pain worse: ______________ What makes the pain better: ______________

Is the condition: ☐ Getting Worse ☐ Getting Better ☐ Constant ☐ Fluctuating

Does the condition interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Exercise

Have you had this or similar conditions in the past ☐ Yes ☐ No

Have you been treated by a Medical Physician for this issue: ☐ Yes ☐ No If Yes, Where: ______________

Have you ever been treated by a Chiropractor before ☐ Yes ☐ No If Yes, Whom: ______________

EMERGENCY CONTACT

Name: ______________________ Relationship to you: ____________ Phone # : ____________

Who is your Primary Physician: ______________________

HEALTH HISTORY

Do you have any Allergies: ☐ No ☐ Yes Please List: ______________________

List previous surgeries/treatments including dates: ______________________

List any past serious accidents with dates: ______________________

Are you currently taking any medications: ☐ No ☐ Yes

Please List Medication and Dosage:

____

____

Please Continue On Back

Have you ever had any of the following medical conditions:

- ☐ Heart Attack/Stroke
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis
- ☐ Frequent Neck Pain
- ☐ Psychiatric Problems
- ☐ Kidney Problems
- ☐ Diabetes/Tuberculosis
- ☐ Articial Bones/Joints
- ☐ Heart Surgery/Pacemaker
- ☐ Artificial Valves
- ☐ HIV+/Aids
- ☐ Emphysema/Glaucoma
- ☐ Rheumatic Fever
- ☐ Ulcers/Colitis
- ☐ Difficulty Breathing
- ☐ Arthritis
- ☐ Heart Murmer
- ☐ Venereal Disease
- ☐ Shingles
- ☐ Anemia
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Congenial Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Cancer/Chemotherapy
- ☐ High/Low Blood Pressure
- ☐ Severe/Frequent Headaches
- ☐ Fainting/Seizures
- ☐ Epilepsy
- ☐ Lower Back Problem

Family Health History (Ex: Stroke, Cancer, Diabetes, Arthritis, et c.)

Father: ______________________ Mother: ______________________

Brother: ______________________ Sister: ______________________

Do You Smoke: ☐ Yes ☐ No How Much: __________ Do You Drink Alcohol: ☐ Yes ☐ No How Much: __________

Do you use Recreational Drugs: ☐ Yes ☐ No How Much: __________ Do you Wear: ☐ Arch Supports ☐ Heal Lift

Are you taking Birth Control: ☐ Yes ☐ No Are you Pregnant: ☐ Yes ☐ No Are you Nursing: ☐ Yes ☐ No

INSURANCE INFORMATION

Insurance Name: ______________ ID #: ______________ Group #: ______________

Insured's Name: ______________ Insured's Relation: ______________ Insured's DOB: ______________

Claim ID #: ______________________ ☐ Workman's Comp ☐ Auto Case

COLLECTION POLICY AND AGREEMENT

Our policy requires payment in full for all services rendered at the time of visit unless other payment arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made your account will be turned over to our Collection Agency.

In the event we must enforce our rights under the City of Peoria, IL Codes and Ordinances, after your failure to pay all charges due within 35 days of our first statement or defaults hearing, you must pay all charges to include collection agency fees, which are typically 33% to 50% of the unpaid balance, reporter's fees, depositions and at trial expenses we incur in enforcing our rights under this Agreement.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: ______________________________ Date: ______________