PHOENIX HEALING s.c.

Confidential Health Information Questionnaire

First Name___________________________ Last Name____

Street Address____

City____________________________________ State_____________ Zip___________________________

E-mail____

Home Phone__________________________ Cell________________________ Work__________________

Date of Birth________________________ Age______________ Marital Status: M S D W

Spouse's Name____ Spouse's Date of Birth___________

Insurance Company____

Employer___________________________________ Occupation__________________________________

Employment Status: F/T P/T Retired Not Employed Student

How were you referred to Dr. Amy Laquinta?

Friend:______________________________________ Internet: (site)______________________________

Ad:____ Escape2 Salon Employee______________________

Other: (please be specific)____

List Present Complaints, injuries and duration:

1.____

2.____

3.____

Have you had chiropractic care before? Y N Do you have a primary care doctor? Y N

Name of doctor and approx. date of last visit____

Name of person to contact in event of an emergency____

Relationship to you____________________________ Contact number_____________________________

Patient's Name____

Patient's Signature____________________________________Date_____________________________

HEAD:
D Headache
- o sinus (allergy)
- o entire head
- o back of head
- o forehead
- D temples
- o migraine

o Head feels heavy
o Loss of memory
o Light-headedness
D Fainting
D Light bothers eyes
o Blurred vision
o Double vision
o Loss of vision
D Loss of taste
D Loss of balance
o Dizziness
o Loss ofhearing
o Pain in ears
o Ringing in ears
o Buzzing in ears

NECK:
o Pain in neck
o Neck pain with movement
- o Forward
- D Backward
- o Tum to left
- D Tum to right
- o Bend to left
- D Bend to right

D Pinched nerve in neck D
Neck feels out of place o
Muscle spasms in neck
o Grinding sounds in neck
o Popping sounds in neck
o Arthritis in neck

SHOULDERS:
o Pain in shoulder joint [R L]
o Pain across shoulders
o Bursitis [R L]
o Arthritis [R L] D
Can't raise arm
- o above shoulder level
- o over head

o Tension in shoulders
D Pinched nerve in shoulder [R L]
o Muscle spasms in shoudler

ARMS & HANDS:
o Pain in upper arm [R L]
o Pain in elbow [R L]
o Movement aggravated
o Tennis elbow [R L]
D Pain in forearm [R L]
D Pain in hands [R L]
o Pain in fingers [R L]
o Pins & needles in arms [R L]
D Pins & needles in fingers [R L]

ARMS & HANDS (cont):
o Numbness in arms [R L]
o Numbness in fingers [R L]
o Fingers go to sleep [R L]
o Hands cold [R L]
o Swollen joints in fingers [R L]
o Sore joints in fingers [R L]
o Arthriti s in fingers [R L]
o Loss of grip strengt h [R L]

MID-BACK:
o Mid-back pain
o Location ___:------:-:-:-:---:--
D Pain between shoulder blades
o Sharp slabbing
o Dull ache
o Pain from front to back
o Muscle spasms
o Pain in kidney area

CHEST:
o Chest pain
D Shortness of breath
o Pain around ribs
o Breast pain
o Dimpled or orange-peel breast
o Irregular heartbeat

ABDOMEN:
D Nervous stomach
o Foods can't eat
o Nausea
o Gas
o Constipation
D Diarrhea
G Hemorroids

LOW BACK:
o Low back pain
- o Upper lumbar
- o Lower lumba r
- o Sacroilli ac

o Low back pain is worse when:
- o working
- o lifting
- O stooping
- o standing
- o sitting
- P bending
- o coughing D
- lying down (sleeping)
- o walking

o Pain relieves when __ __ __ __
o Slipped Disc
o Low back feels out of place
D Muscle spasms
o Arthritis

HIPS, LEGS, & FEET: o
Pa in in buttocks [R L] D
Pain in hip joint [R L] o
Pain dow n leg [R L]
o Pain down both legs
o Knee pai n [R L]
- o Inside
- o Outside

o Leg cramps [R L]
o Cramps in feet [R L]
o Pins & needles in leg [R L]
- o Numbness of leg [R L]

o Num bness of feet [R L]
o Numbness of toes [R L]
o Feet feel co ld [R L]
o Swollen ankles [R L]
o Swollen feet [R L]

WOMEN ONLY:
o Menstrual pain ____________(where)
o Cra mping
o Irregul arity
o Cycle days
o Birth control _____________ (type)
o Hyserectom y
o Genital cancer ____________________
D Disc harge
D Menopau se ______________________
o Tumors
o Abortions
o Are you or do you think you might be pregnant?

MEN ONLY:
D Frequent urination D
Diffic ulty in sta rting
o Night urination
- o Pro tate pain/swe lling

GENERAL:
D Nervousn ess
D Irrita ble
o Depressed
o Fatigue
o Generally feel ing run-down
o Norma l sleep ______
o Loss of sleep
o Loss of weight . hrs./night
o Gain weight lbs.
o Coffee lbs.
o Tea __ __ __ . cups/day s/day __
o Cigarettes_____ _____ pack/da y
o Diabetes
o Hypoglycemi a
n Other __ __ __

REMARKS:

PHOENIX HEALING s.c.

322 Happ rd. Northfield , Il 60093

Privacy Policy

We are very concerned with protecting your privacy. We may disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health, to another party is they are potentially responsible for the payment of your services, or within our practice for quality control.

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. Any requests, such as these, must be made in writing. However, we are not required to agree to your restrictions.

Your chiropractor and members of the staff may need to use your: name, address, phone number, and your clinical records to contact your with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you.

If this contact is made by phone and you do not answer, a message will be left on your answering machine. Our office sends out new patient letters, post cards. birthday cards and statements periodically.

By signing this, you give Dr. Amy Laquinta and Phoenix Healing permission to send mail to the address and or email address given on your introductory paperwork. You are consenting to treatment and. if needed, allowing Phoenix Healing to bill your insurance and have the payment send straight to our office.

Name Printed_______________________________________ Date_____________

Patient Signature____________________________________ Authorized Rep._____________

PHOENIX HEALING s.c.

322 Happ rd. Northfield , Il 6009

Consent for Care

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

THE NATURE OF THE ADJUSTMENT:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. You may or may not feel some movement.

ANALYSIS/EXAMINATION/TREATMENT:

As part of the analysis, examination and treatment, you are consenting to the following procedures although depending on your case not all may be used on you.

____Spinal Manipulative Therapy	____Palpation	____Vital Signs
____Range of Motion Testing	____Orthopedic Testing	____Basic Neurological Testing
____Muscle Strength Testing	____Postural Analysis	____EMS
____Ultrasound	____Hot/Cold Therapy	____X-rays

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

THE PROBABILITY OF THOSE RISKS OCCURING:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and if X-rays are taken. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Since my adjustments never involve the twisting of the cervical spine and do not involve any high-velocity

forces the risk would be even less than that. The other complications are also generally described as rare.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS:

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Amy Laquinta and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _______________ Dated: _______________

_______________________________ _________________________________

Patient's Name Doctor's Name

_______________________________ _________________________________

Signature Signature

_______________________________ Signature of Parent or Guardian (if a minor)

HOENIX HEALING s.c.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Private and group accident and health insurance

I hereby direct and instruct my insurance company to pay by check made out and mailed directly to,

Phoenix Healing S. C.
1920 Sunset Ridge Rd. Glenview. IL 60025

If my current policy prohibits direct payment to doctor. then I hereby also direct and instruct you to make out the check to me and mail it as follows,

Phoenix Healing S.C.
1920 Sunset Ridge Rd. Glenview. IL 60025

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment towards the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee. and I have agreed to pay. in current manner. any balance of said professional service charges over and above the insurance payment.

MEDICARE PATIENTS ONLY

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1962 (a) (1) of the Medicare law. If Medicare determined that a paliicular service. although it would otherwise be covered. is "not medically necessary" under Medicare program standards. Medicare will deny payment for that service. A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information peliinent to my case to any insurance company. adjuster. or attorney involved in this case. Use this form as an example of my "signature on file". I have been notified by my physician that Medicare is likely to deny payment for any x-rays taken and any examinations performed and I agree to be personally responsible for the payment of the agreed services.

DATED AT.________________THIS DAY OF_______. 20_____

SIGNATURE OF POLICY HOLDER ____

WITNESS____

SIGNATURE OF CLAIMANT IF OTHER THAN POLICYHOLDER

____