LAKE ZURICH WELLNESS GROUP

165 S. Rand Rd ● Lake Zurich, IL 60047 ● (O) : 847 - 550 - 4094 ● (F) : 847 - 550 - 4096

PATIENT INFORMATION

Name: ______________________________________

Address: ______________________________________

City: ________________ State: ____ Zip: _________

Date of birth : _____ / _____ / _____ Sex ☐ M ☐ F

Marital Status : ☐ M ☐ S ☐ W ☐ D

Phone: (_______)___________ ☐ Home ☐ Cell ☐ Work

Phone: (_______)___________ ☐ Home ☐ Cell ☐ Work

Phone: (_______)___________ ☐ Home ☐ Cell ☐ Work

E-Mail: ___________________________

Primary Care Physician: ________________________

Referring Physician: ___________________________

EMERGENCY CONTACT INFORMATION

Name **Relationship** **Phone**

____

RESPONSIBLE PARTY (If patient is un der 18 years of age)

Name: ______________________________________

Address: ____________________________________

City: ________________ State: ____ Zip: _________

Phone: (_____)__________ ☐ Home ☐ Cell ☐ Work

Phone: (_____)__________ ☐ Home ☐ Cell ☐ Work

PATIENT EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer: _______________________

Phone: (_____)__________ Occupation: _____________

INSURANCE INFORMATION

☐ I do not have health insurance

Insurance Company: ______________________________ ID #: ________________ Group #: ________________

Subscriber Name: ______________________________________ Subscriber's Date of birth : _____ / _____ / _____

Relationship to Subscriber : _________ Subscriber's Phone: (_____)__________ ☐ Home ☐ Cell ☐ Work

Is your visit a result of a motor vehicle / work accident? ☐ Yes ☐ No **(if yes, please inform the front desk)**

MEDICAL HISTORY (please check all that apply) ☐ **None apply**

☐ Heart attack	☐ Osteoporosis	☐ Gout	☐ Transplants
☐ Heart Failure	☐ Osteoarthritis	☐ Stomach Ulcer	☐ Phlebitis
☐ Heart Murmur	☐ Asthma	☐ Kidney Stones	☐ Blood clots in legs
☐ High Blood Pressure	☐ Pneumonia	☐ Kidney failure	☐ Blood clots in lungs
☐ Low Blood Pressure	☐ Tuberculosis	☐ Alcohol Dependence	☐ Insomnia
☐ High Cholesterol	☐ Emphysema	☐ Pacemaker	☐ GERD
☐ Rheumatoid arthritis	☐ Lung Disease	☐ HIV Positive / AIDS	☐ Loss of Memory
☐ Peripheral neuropathy	☐ Blood vessel Disease	☐ Hepatitis	☐ Cold Hands / Feet
☐ Peripheral vascular disease	☐ Mental Illness	☐ Lupus	☐ Hand Tremors
☐ Coronary artery disease	☐ Sleep apnea	☐ Liver Problems	☐ Epilepsy
☐ Bulging / Herniated disc	☐ ADHD / ADD	☐ Hyperthyroidism	☐ Stroke
☐ Spinal stenosis	☐ Gall Bladder Problems	☐ Hypothyroidism	☐ Diabetes
☐ *Cancer (please explain below)	☐ Other (please explain below)	☐ Hyperlipidemia	

* Explanation: ____

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or office and authorize the office to furnish information regarding my illness to my insurance carrier. **I understand that I am responsible for any amount not paid by my insurance company.**

Patient Signature: _____________________________ Date: _________ Account# :____________________

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HISTORY OF PRESENT PROBLEM

Chief complaint: (why are you seeing the doctor today): ______________________________

How long have you had this problem: ____________________ Has the pain ever been a level 9 or 10? ☐ Yes ☐ No

When do you feel it most? ☐ AM ☐ PM ☐ All Day How long does the complaint last? _____ Mins _____ Hrs

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild — Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

Does anything make your chief complaint better? ☐ Yes ☐ No

If yes, please explain : ______________________________

Does anything make your chief complaint worse? ☐ Yes ☐ No

If yes, please explain : ______________________________

Have you been treated previously for this condition? ☐ Yes ☐ No

Prior treatments for your chief complaint include: ☐ Chiropractic ☐ Physical Therapy ☐ Medical Doctor / Orthopedic

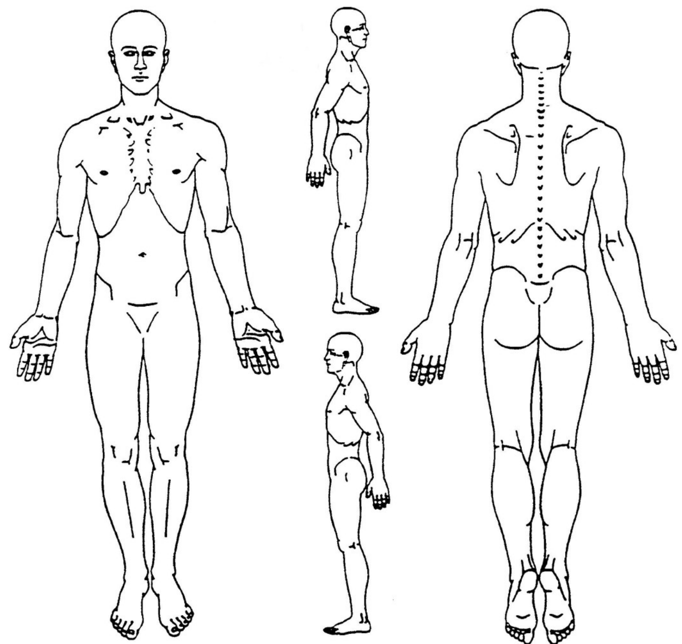
☐ Hospitalization ☐ Anti-Inflammatory ☐ Pain Medication ☐ Injection ☐ Heat/Ice ☐ Exercise ☐ Massage

☐ Other (please list) : ______________________________

Please indicate the name of facility/physician and date of last visit: ______________________________

On the diagram to the right, please indicate where you are experiencing your chief complaint by placing the letter(s) on the left on that specific area.

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain



Mark all activities that your chief complaint causes you to have trouble performing ? ☐ Standing ☐ Sitting

☐ Walking ☐ Running ☐ Bending ☐ Twisting

☐ Carrying objects ☐ Sleeping ☐ Driving ☐ Kneeling

☐ Lifting objects ☐ Lifting children ☐ Exercising

☐ Housework ☐ Personal Grooming

☐ Other : ____________________

Patient Name (please print): ______________________________ Account # ____________

Patient Signature ______________________________ Date: __________

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

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Social History

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

Do you have children? ☐ Yes ☐ No If yes, what are their ages: ______________________

Are you, or could you be, pregnant? ☐ Yes ☐ No

What was the first day of your last menstrual cycle? ______________________________

Risk Factors

Do you smoke or use tobacco? ☐ Daily ☐ Occasionally ☐ Former ☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No If yes, indicate quantity: _____ drink per ☐ Day ☐ Week ☐ Month

Do you Exercise? ☐ Yes ☐ No What type?: __________________________ How many days per week? _________

Family History (check all that apply) ☐ None apply

Condition	Family Member (s)	Condition	Family Member(s)
☐ Heart disease	______________________	☐ Scoliosis	______________________
☐ Stroke	______________________	☐ Spine problems	______________________
☐ High Blood Pressure	______________________	☐ Kidney failure	______________________
☐ Diabetes	______________________	☐ Mental illness	______________________
☐ Osteoporosis	______________________	☐ Bleeding disorders	______________________
☐ Rheumatoid Arthritis	______________________	☐ Anemia	______________________
☐ Osteo Arthritis	______________________	☐ Alcohol dependence	______________________
☐ Lupus	______________________	☐ Cancer	______________________
☐ Sickle Cell	______________________	☐ Other: __________	______________________

Medications / Supplements you take ☐ None apply

Name	Dosage & Frequency	Who prescribed	Reason for taking

Patient Name (please print): ____________________________________ Account # ______________

Patient Signature ______________________________ Date: __________

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