

# APPLICATION FOR CARE AT HEALTH FROM WITHIN

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Name of Spouse: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Names and Ages of your children: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

**WOMEN ONLY:** Are you pregnant or nursing? No \_\_\_\_\_ Yes \_\_\_\_\_

## HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

**Chief complaint:** \_\_\_\_\_

**All Other** problems or symptoms you are experiencing: \_\_\_\_\_

When did the problem(s) begin? \_\_\_\_\_ is your problem the result of ANY type of accident.  Yes  No

If **yes** identify type:  Auto  Work  Home  Other (please explain): \_\_\_\_\_

Date of Accident: \_\_\_\_-\_\_\_\_-\_\_\_\_ approximately what time that day? \_\_\_\_am \_\_\_\_pm

Have you reported this accident to anyone?  No  Yes if yes to whom: \_\_\_\_\_

Have you suffered with any of this or a similar problem in the past?  No  Yes If yes how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ Other forms of treatment tried?  No  Yes **If yes**, please state **what** type of treatment you have tried \_\_\_\_\_, and **who** provided it: \_\_\_\_\_

How long ago? \_\_\_\_\_

What were the results?  Favorable  Unfavorable → please explain. \_\_\_\_\_

**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R = Radiating B = Burning D = Dull A = Aching N = Numbness**  
**S = Sharp/ Stabbing T = Tingling**

When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant  I experience it intermittently

What relieves your symptom(s) \_\_\_\_\_?

What makes them feel worse? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes If yes when: \_\_\_\_\_

by whom? \_\_\_\_\_

What were the results? \_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_

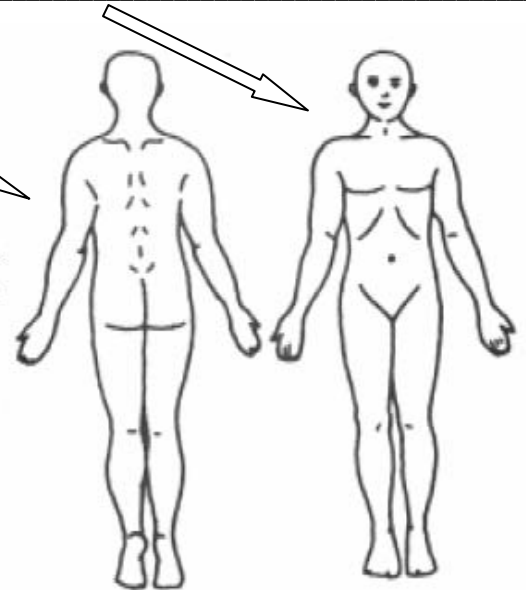
How long were you under care: \_\_\_\_\_ How long ago? \_\_\_\_\_

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain, rate how you feel today **(Circle the number)**:

**Primary** or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaints is a : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 **Fourth** complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



## PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Disability \_\_\_ Fracture \_\_\_ Rheumatoid Arthritis \_\_\_ Cancer  
 \_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Stroke \_\_\_ Seizure \_\_\_ Concussion \_\_\_ Other serious conditions: \_\_\_\_\_

For Doctors use only:

2. PLEASE, identify ALL PAST and any CURRENT conditions you feel may be contributing your present problem:

HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS →		
INJURIES →		
SURGERIES →		
CHILDHOOD DISEASES →		
ADULT DISEASES →		

Reserved for doctor's use only Systems reviewed with patient:

- Musculoskeletal
- Neurological

**SOCIAL HISTORY**

1. Smoking:  cigars  pipe  cigarettes → How often?  Daily  Weekends  Occasionally  Never
2. Alcoholic Beverage: consumption occurs →  Daily  Weekends  Occasionally  Never
3. Recreational Drug use:  Daily  Weekends  Occasionally  Never

4. Hobbies -Recreational Activities- Exercise Regime: How does you present problem affect the following:

IDENTIFY TYPE:

EFFECT:

- |       |                                    |   |   |  |
|-------|------------------------------------|---|---|--|
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

5. Work Activities: Please complete all questions!

- Hours worked per day: \_\_\_\_\_ Days per week: \_\_\_\_\_ Does your job require lifting?  No  Yes If yes, what is the maximum required?  Min (<5 lbs)  Light (5-20 lbs)  Med (20-50lbs)  Hvy (>50 lbs)
- Lifting Frequency:  Constant (66-100%of day)  Frequent (33-66% of day)  Occasional (0-33% of day)
- Lifting Postures:  Knee  Torso  Arm  Shoulder  Off Posture
- Standing: \_\_\_\_\_ Hrs per day    Sitting: \_\_\_\_\_ Hrs per day    Pushing: \_\_\_\_\_ Hrs per day
- Twisting: \_\_\_\_\_ Hrs per day    Climbing: \_\_\_\_\_ Hrs per day    Pulling: \_\_\_\_\_ Hrs per day
- Kneeling: \_\_\_\_\_ Hrs per day    Reaching: \_\_\_\_\_ Hrs per day    Walking: \_\_\_\_\_ Hrs per day

6. Repetitive Activities:

- Computer: \_\_\_\_\_ Hrs per day    Grasping: \_\_\_\_\_ Hours per day    Hand Tools: \_\_\_\_\_ Hrs per day
- Machinery: \_\_\_\_\_ Hrs per day    Assembly: \_\_\_\_\_ Hrs per day    Phone: \_\_\_\_\_ Hrs per day
- Other: \_\_\_\_\_ Hrs per day

7. Impact of Current Condition on Work Capacity:  No Effect  Painful  Limits  Unable to work

8. How many years of school did you complete?  1-8  8-12  12-14  14-16  16 +

**FAMILY HISTORY:**

1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
 If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)
2. Have they ever been treated for their condition?  No  Yes  I don't know
3. Any other hereditary conditions the doctor should be aware of.  No  Yes: \_\_\_\_\_



I hereby authorize payment to be made directly to Health From Within, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to HFW for any and all services I receive at this office.

\_\_\_\_\_  
 Patient or Authorized Person's Signature

\_\_\_\_\_  
 Date Completed

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Patient signature



# NOTICE OF HIPAA PRIVACY PRACTICE

**HEALTH FROM WITHIN** is required to notify you writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign and return it to our front desk receptionist.

## PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any available collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

## YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them

## COMPLAINTS:

If you wish to make a formal complaints about how we handle your health information please call Danielle LeMonnier at 708-349-0040. If she is unavailable, you may make an appointment with our receptionist to speak with her within 2 working days. If you are still not satisfied wit the manner in which this office handles your complaint, you can submit a formal complaint to: HFW 14400 S. John Humphrey Dr. Ste 110 Orland Park, IL 60462.

**Note:** This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of Health From Within Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date