LoneStar Chiropractic and Wellness Center, LLC
Jenna A. Ewers, D.C.
852 Sharp Drive, Unit J, Shorewood, IL 60404

CONFIDENTIAL PATIENT HISTORY

DATE: _____

Name_____ DOB_____ Sex____ SS#_____

Address_____ City_____ State____ Zip_____

Marital Status: M S W D Spouse's Name_____ # of children_____

Phone (home)_____ (cell)_____ (work)_____

Email_____Occupation_____Employer_____

Emergency Contact_____Phone_____Cell_____

Preferred form of contact *work * home *cell *mail * e- mail

Whom may we thank for referring you to this office? _____

Have you had previous chiropractic care? *yes *no

Describe your experience_____

Describe your present major complaints (rating pain on a scale of 1-10 with 10 being highest)

_____

_____

Symptoms are worse *Morning *Afternoon *Night

How occurred_____

_____Date occurred_____

Symptoms developed from: (circle one)

*Job related injury *Auto accident *Other accident * Illness *Unknown cause *Gradual Onset

Is this condition getting progressively worse? * Yes * No *Constant * Comes and Goes

Is this condition interfering with the following? ☐Work ☐Sleep ☐Daily Routine ☐Other_____

Other doctors who treated this condition _____

List any complaints_____

Have you ever been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

Describe_____

Have you had any other injuries or accidents (including fractures, dislocation, childhood trauma)?
☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never

Describe_____

CONFIDENTIAL PATIENT HISTORY

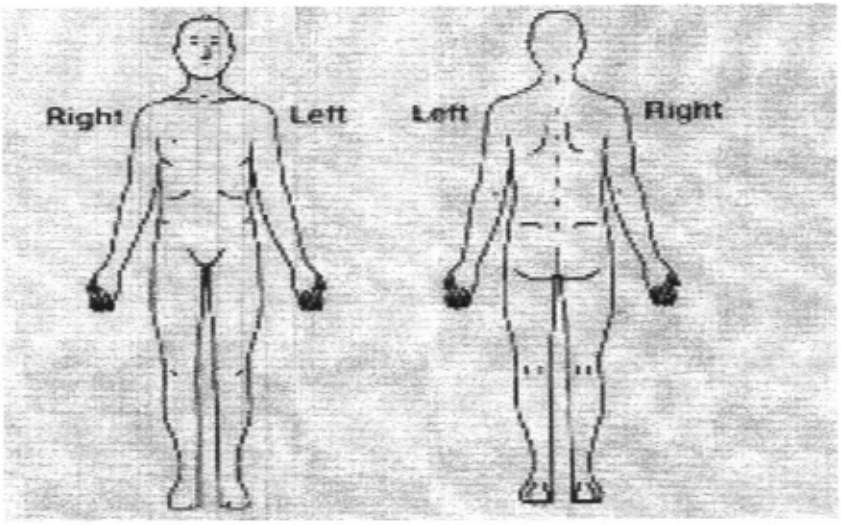
Patient's Name:_____ Date_____

Have you had or do you now have any of the following symptoms that have been of significant distress to you?

Indicate by circling **N: within the last 6 months** **P: ever had in past** **X: family history of condition**

	Now N	Past P	FHx X
Headaches	N	P	X
Cancer	N	P	X
Depression	N	P	X
Diarrhea	N	P	X
Hemorrhoids	N	P	X
Belching	N	P	X
Asthma	N	P	X
Neck Pain	N	P	X
Back Pain	N	P	X
Knee Pain	N	P	X
Arthritis	N	P	X
Swollen Joints	N	P	X
Muscle Aches	N	P	X
Scoliosis	N	P	X
Nerve Disease	N	P	X
Fatigue	N	P	X
Foot/Hand Pain	N	P	X
Upset Stomach	N	P	X
Sinus Problems	N	P	X
Triglycerides	N	P	X
Allergies	N	P	X
Menstrual Issues	N	P	X
Memory Loss	N	P	X
Urinary Tract Problems	N	P	X
Constipation	N	P	X
Vomiting	N	P	X
Stroke	N	P	X
Seizures/Epilepsy	N	P	X
Weakness	N	P	X
Cold Sweats	N	P	X
Indigestion	N	P	X
Colitis	N	P	X
Hernia	N	P	X
Nervousness	N	P	X
Diabetes	N	P	X
Fever	N	P	X
Stiffness	N	P	X
Ulcers	N	P	X
Ringing/Buzzing in Ears	N	P	X
Easily Bruise and Bleed	N	P	X
Anemia	N	P	X
Hot Flashes	N	P	X
Numbness/Tingling	N	P	X
Kidney Disease	N	P	X
Dizziness/Fainting	N	P	X
Irritability	N	P	X
Osteoporosis	N	P	X
Cold Hands/Feet	N	P	X
Frequent Colds	N	P	X
Dental Problems	N	P	X
Shortness of Breath	N	P	X
Pulmonary Disease	N	P	X
Cholesterol	N	P	X
Heart Condition	N	P	X
Thyroid Disease	N	P	X
Shoulder Pain	N	P	X
Gall Bladder	N	P	X
Liver Disease	N	P	X
Muscle Disease	N	P	X
Other _____	N	P	X

Mark all the areas on your body where you feel the described sensations.
Use the appropriate symbol to mark all affected areas.



Aching	Numbness	Burning	Stabbing	Pins & Needles
*****	^^^^^^^	xxxx	//////	ooooooo

_____

Patient's Signature Date

FINANCIAL AGREEMENT

I hereby authorize the Doctor to work with my condition through the use of adjustments, manual therapy, therapeutic exercise or any other treatment as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Cancellation policy

We do everything we can to provide the best possible service to all our clients by adhering to a schedule to the best of our abilities. When a client fails to make their appointment time, or cancels at the last minute, that time slot is wasted which could have been used for another patient needing treatment. Given this fact, we require a twenty-four hour cancellation notice. If a client cancels without sufficient notice, we will be forced to charge a $30.00 late cancellation/no show fee.

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name: (Please Print)	**Signature:**
Guardian or Spouse authorizing care:	**Date:**

Who should receive bills for payment on your account? (circle one)

Patient **Spouse** **Worker's Comp** **Auto Insurance** **Medicare** **Health Insurance**

Informed Consent of Examination and Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulations are required by law to obtain your informed consent before starting treatment.

I_____, of_____
(name) (City, State)

do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of examination and manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercise may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medication, exercises and possible surgery.

Informed Consent of Examination and Treatment (page 2)

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest in not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ _____

Patient's Name Witness

_____ _____

Patient's Signature
(or Responsible Authority) Date

Consent to treat a Minor

I hereby request and authorize Dr. Jenna Ewers and/or Dr. Janine Smith to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Parent or Guardian signature:_____

Parent or Guardian:_____

Date:_____ Witness:_____