PATIENT INFORMATION FORM

Last Name: _____ **First**: _____ **MI**: _____

Address: _____ **City/State**: _____ **Zip**: _____

Date of Birth: _____ **Social Security #** _____ **Gender**: ____

E-Mail Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

If you are not available at the time of the phone call,
can we disclose information in a message: Please circle one: Yes No

Occupation: _____ How Many Years _____

Employer: _____

Insurance: (copy of card required) _____

Policy holder name: _____ Date of Birth: _____

Who referred you to our office: _____

Emergency Contact

Name: _____ Relationship: _____

Emergency Contact Number: _____

Name of Authorized Guardian if patient is a minor: _____

Dr. Annie C. Wang
WANG CHIROPRACTIC & ACUPUNCTURE CLINIC
552-A S York Street
Elmhurst, IL 60126
630 / 941-1234
Fax: 630 / 833-5288

PATIENT QUESTIONNAIRE

Name: _____

Age: _____ Height: _____ Weight: _____

What is your chief complaint (reason you are seeking care)? _____

_____

When did the pain start? _____

How did your pain start? _____

Have you seen any other provider (doctor) for this condition? Who? _____

Have you had any: X-Rays MRI CT Scan Ultra Sound Blood Tests

When? Where? _____

Does the pain radiate. shoot, travel: _____

When & how does your pain occur? Constant _____ Intermittent ___ # Hours/day _____

Lifting _____	Walking _____	Sitting _____	Bending _____
Exercising _____	Standing _____	Lying Down ____	Coughing _____
Sneezing _____	Bowel Movement _	Urinating _____	Resting _____
Weather Changes _____		Other _____	

What makes your pain worse?

Lying down ____	Standing _____	Bending _____	Sitting _____
Walking _____	Stress _____	Massage _____	Sex _____
Heat _____	Cold _____	Other _____	

Describe your pain. Check all that apply.

Aching _____	Burning _____	Cramping _____	Cutting _____
Electric Shock ___	Excruciating ____	Intense _____	Intolerable _____
Itching _____	Mild _____	Moderate _____	Numbing _____
Piercing _____	Pins & Needles ___	Pulsating _____	Severe _____
Sharp _____	Shooting _____	Squeezing _____	Stabbing _____
Stinging _____	Throbbing _____	Tingling _____	

Since starting, has your pain: Stayed the Same___ Increased _____ Decreased _____

Do you have trouble sleeping due to your pain: _____

Does the pain wake you? _____

How many hours can you sleep uninterrupted before the pain wakes you? _____

What relieves your pain?

Lying Down ___	Massage _____	Heat _____	Cold _____
Standing _____	Sitting _____	TENS _____	Acupuncture ___
Alcohol _____	Nerve Blocks _____	Drugs _____	P.T. _____

HIPAA ACKNOWLEDGMENT - NOTICE OF PRIVACY PRACTICES

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq. and regulations there under, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that our office (Practice") or its Business Associates may use or disclose your Protective Health Information (PHI) for the purpose of providing treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes. Further, you acknowledge that you have read and understand our office's Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. You are also, acknowledging that you have reviewed, understand and agree to the Notice of Privacy Practices of our office which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by this Practice.

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, or any other health plan to Wang Chiropractic & Acupuncture Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original I hereby authorize said assignee to release all necessary information to insurance carriers or any other services including billing and transcription concerning my illness and treatments in order to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Acknowledged and Agreed to by:

Patient:

Print Name: _____ Date: _____

Patient Signature: _____

OR, on Behalf of Patient:

Print Name: _____ Date: _____

Signature: _____

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INFORMED CONSENT
FOR
ACUPUNCTURE AND CHIROPRACTOR SERVICES

I hereby request and consent to the performance of acupuncture, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctor of chiropractics who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractics there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure and which the doctor feels at the time, based upon the facts, to be in my best interest.

I have read and/or have had it read to me, the above consent. I have had an opportunity to ask questions about this consent and by signing below, agree to chiropractic procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

To be completed by patient (or representative):

_____
Print Patient's Name

_____ _____
Patient's Signature Date

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