For Office Use Only

Patient's Name: _____ DOB: ____/____/_____ Chart #: _____

97140 98943 97110 97530 97112 L3030 97014 97035

Landgrebe Chiropractic P.C.

6828 171st Street
Tinley Park, IL 60477
708-429-4332
www.LandgrebeChiro.com

Dr. Charles Landgrebe
Dr. Alexis Landgrebe

NEW PATIENT INTAKE FORM

Name _____ Date _____

Home Address:

Street: _____

City: _____ State: _____ ZIP: _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

☐ check here if you would like to receive our monthly newsletter with health tips and other health information

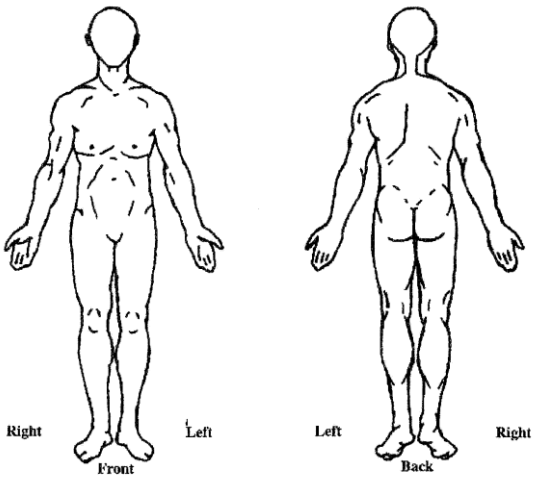
Social Security # ___-___-_____ Birth Date ___/___/_____

Employer/School _____ Occupation _____

Employer's Address _____

Who is your general practitioner? _____

Aching	Numbness	Pins & Needles	Burning	Stabbing
***	= = =	000	XXX	/ / /



Pain Diagram

Visual Analog Scale

The line below represents the intensity of your pain. Please place an "X" on the line that indicates how much pain you feel at this time. Mark the pain location on the pain diagram.

No Pain — Worst Pain imaginable

Please check any box below that is applicable

I am interested in:

- ☐ Nutritional Counseling
- ☐ Physical Therapy
- ☐ Weight Management
- ☐ Rehabilitation
- ☐ Gait Analysis
- ☐ Massage Therapy

How did you hear about us?

☐ Please check here if you have never seen a chiropractor before

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CONFIDENTIAL HEALTH HISTORY

The items below may relate to your current condition. In the space in front of each item, place a P, if you PRESENTLY have the problem and an H if you previously HAD the problem. Leave space blank if you NEVER had the problem.

GENERAL

1 ___ Loss of Sleep
2 ___ Fatigue
3 ___ Nervousness
4 ___ Weight Loss or Gain
5 ___ Allergies
6 ___ Bleeding Problem
7 ___ Anemia
8 ___ Diabetes
9 ___ Cancer
10 ___ Fever
11 ___ Chills
12 ___ Night Sweats
13 ___ HIV Risk Factors

EYES, EARS, NOSE AND THROAT

14 ___ Poor Vision
15 ___ Pain in Eye(s)
16 ___ Deafness/Difficulty Hearing
17 ___ Nosebleeds
18 ___ Nose Problems
19 ___ Sinus Trouble
20 ___ Dental Problems
21 ___ Hoarseness
22 ___ Tonsil or Adenoid Problem

GASTROINTESTINAL

23 ___ Poor Appetite
24 ___ Poor Digestion
25 ___ Difficulty Swallowing
26 ___ Belching or Gas
27 ___ Frequent Nausea
28 ___ Vomiting
29 ___ Vomiting Blood
30 ___ Pain Over the Abdomen
31 ___ Ulcer
32 ___ Black or Bloody Stools
33 ___ Liver Problems
34 ___ Gall Bladder Problems
35 ___ Jaundice
36 ___ Hernia
37 ___ Diarrhea
38 ___ Constipation
39 ___ Hemorrhoids
40 ___ Appendicitis

WOMEN ONLY

41 ___ Live Births
42 ___ Miscarriage
43 ___ Painful Periods
44 ___ Excessive Flow
45 ___ Irregular Cycles
46 ___ Vaginal Burning/Itching
47 ___ Hot Flashes
48 Date Last Period Began _____.
49 Date of Last PAP Test _____.
50 Date of Last Mammogram _____.

RESPIRATORY

51 ___ Difficulty Breathing
52 ___ Chronic Cough
53 ___ Spitting Phlegm
54 ___ Spitting Blood
55 ___ Wheezing/Asthma
56 ___ Pneumonia
57 ___ Tuberculosis

CARDIOVASCULAR

58 ___ Irregular Heartbeat
59 ___ High Blood Pressure
60 ___ Pain Over Heart
61 ___ Previous Heart Trouble
62 ___ Ankle Swelling
63 ___ Varicose Veins
64 ___ Rheumatic Fever
65 ___ Stroke

GENITOURINARY

66 ___ Frequent Urination
67 ___ Painful Urination
68 ___ Blood in Urine
69 ___ Kidney Disease
70 ___ Urinary Infection
71 ___ Inability to Control Urination
72 ___ Difficulty Starting Urine Flow
73 ___ Get Up ___ Times Per Night to Urinate
74 ___ Breast Lump or Pain
75 ___ Venereal Infection/STD
76 ___ Sexual Difficulties

SKIN

77 ___ Itching
78 ___ Bruising Easily
79 ___ Change in Mole(s) or Freckle(s)
80 ___ Skin Cancer

NEUROLOGICAL

81 ___ Weakness
82 ___ Twitching
83 ___ Tremors
84 ___ Headache
85 ___ Fainting
86 ___ Dizziness
87 ___ Convulsions
88 ___ Epilepsy
89 ___ Numbness/Tingling
90 ___ Arm or Leg Pain
91 ___ Mental Disorder

MEN ONLY

92 ___ Testicular Swelling/Pain
93 ___ Prostate Problems

ACCIDENT/TRAUMA

94 ___ Motor Vehicle Accident
95 ___ Other Trauma/Accidents

MUSCULOSKELETAL

96 ___ Neck Stiffness/Pain
97 ___ Pain Between Shoulders
98 ___ Low Back Pain
99 ___ Swollen Joints
100 ___ Painful Joints
101 ___ Muscle Aches/Soreness
102 ___ Spinal Curvature
103 ___ Arthritis

CHILDHOOD DISEASES

104 ___ Mumps
105 ___ Measles
106 ___ Chicken Pox

HOSPITALIZATIONS

107 ___ List Dates and Reasons:

SURGERIES

108 ___ List Dates and Reasons:

MEDICATIONS

109 ___ Prescription
110 ___ Non-prescription

NUTRITIONAL STATUS

111 ___ Describe your nutritional status:

112 ___ Nutritional Supplements:

113 ___ Herbs/Botanicals:

HABITS

114 ___ Smoking _____ packs per day _____ years
115 ___ Drinking Alcoholic Beverages
116 ___ Recreational Drug Use

EXERCISE

117 ___ None
118 ___ 1-2 times a week
119 ___ 3-5 times a week
120 ___ 6-7 times a week

FAMILY HISTORY

121 ___ Diabetes
122 ___ Thyroid Disease/Goiter
123 ___ Kidney Disease
124 ___ High Blood Pressure
125 ___ Heart Disease
126 ___ Cancer
127 ___ Disc Herniation
128 ___ Arthritis or Degenerative Disease
129 ___ Headache

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Patient Consent Form

Use of this form is optional and not required under the HIPAA privacy rule.

Landgrebe Chiropractic P.C.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Landgrebe Chiropractic P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Landgrebe Chiropractic P.C. describes such uses and disclosures more completely.)
I have the right to review the Notice of Privacy Practices prior to signing this consent. Landgrebe Chiropractic P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Charles M. Landgrebe.

With this consent, Landgrebe Chiropractic P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Landgrebe Chiropractic P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Landgrebe Chiropractic P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Landgrebe Chiropractic P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow Landgrebe Chiropractic P.C. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Landgrebe Chiropractic P.C. may decline to provide treatment to me.

Authorization to Bill Insurance **Office Use Only**

Insurance Company _____Group # _____ ID # _____

Name of Guarantor: _____ Guarantor's Date of Birth _____

Guarantor's Social Security Number:_____ Patient's Relationship to Guarantor: Self / Spouse / Child / Other

If Other Please explain: _____

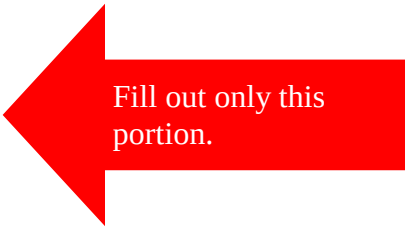
I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance company as indicated above and assign directly to Dr. Charles Landgrebe and/or Dr. Alexis Landgrebe all insurance benefits, if any, otherwise payable to me or services rendered. I understand that I am responsible for all charges whether payable or not payable by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize this signature on all insurance submissions or statements provided to me.

_____
Signature of Patient or Legal Guardian

_____
Date of Consent

_____
Print Name of Patient or Legal Guardian, if applicable

Patient must fill this portion out or treatment will not be rendered



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Welcome! We are excited to serve your health care needs in an effective and efficient manner. Please select times that would work best for your follow-up visits. Please circle <u>all</u> that might apply for any <u>3 days</u>:

<u>Monday</u>:	8:00am-11:00am	11:30am-1:00pm
	1:00pm-4:00pm	4:30pm-6:45pm
<u>Tuesday</u>:	8:00am-11:00am	11:30am-1:00pm
	1:00pm-4:00pm	4:30pm-6:45pm
<u>Wednesday</u>:	8:00am-11:00am	11:30am-1:00pm
	1:00pm-4:00pm	4:30pm-6:45pm
<u>Thursday</u>:	8:00am-11:00am	11:30am-1:00pm
	1:00pm-4:00pm	4:30pm-6:45pm
<u>Friday</u>:	8:00am-11:00am	
	12:00pm-4:00pm	4:30pm-6:15pm
<u>Saturday</u>:	8:00am-10:30am	11:00am-12:45pm

Clinic Hours:	
Monday – Thursday	8:00am-7:00pm
Friday	8:00am-6:30pm
Saturday	8:00am-1:00pm

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this_____day of_____, 20_____

By_____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By_____

Signature of Parent/Guardian (circle one)