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

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

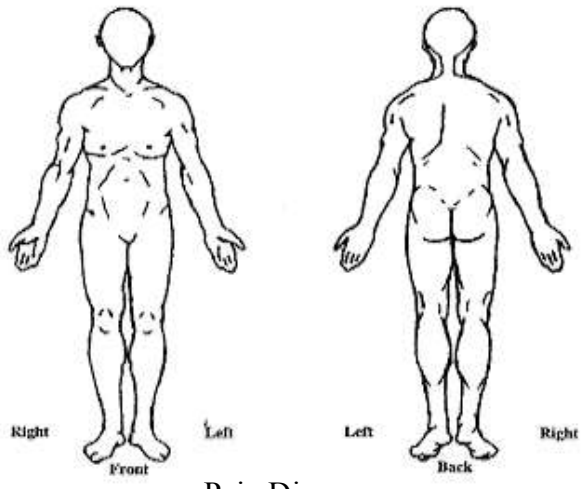
Social Security # ___-___-_____ Birth Date ___/___/_____

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 and mark the pain location on the 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

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

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

EYE, EAR, NOSE, THROAT
17 ____ Poor Vision
18 ____ Pain in Eye(s)
19 ____ Deafness/Difficulty Hearing
20 ____ Nosebleeds
21 ____ Nose Problems
22 ____ Sinus Trouble
23 ____ Dental Problems
24 ____ Hoarseness
25 ____ Tonsillectomy

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

WOMEN ONLY
44 ____ Live Births
45 ____ Miscarriage
46 ____ Painful Periods
47 ____ Excessive Flow
48 ____ Irregular Cycles
49 ____ Vaginal Burning/Itching
50 ____ Hot Flashes
51 Date Last Period Began: _____
52 Date of Last PAP Test: _____
53 Date of Last Mammogram: _____

RESPIRATORY
54 ____ Difficult Breathing
55 ____ Chronic Cough
56 ____ Spitting Phlegm
57 ____ Spitting Blood
58 ____ Wheezing/Asthma
59 ____ Pneumonia
60 ____ Tuberculosis

CARDIOVASCULAR
61 ____ Irregular Heartbeat
62 ____ High Blood Pressure
63 ____ Pain Over Heart
64 ____ Previous Heart Trouble
65 ____ Ankle Swelling
66 ____ Varicose Veins
67 ____ Rheumatic Fever
68 ____ Stroke

GENITOURINARY
69 ____ Frequent Urination
70 ____ Painful Urination
71 ____ Blood in Urine
72 ____ Kidney Disease
73 ____ Urinary Infection
74 ____ Inability to Control Urination
75 ____ Difficulty Starting Urine Flow
76 ____ Get up ____ times per night to urinate
77 ____ Breast Lump or Pain
78 ____ Venereal Infection
79 ____ Sexual Difficulties

SKIN
80 ____ Itching
81 ____ Bruising Easily
82 ____ Change in Mole(s)
83 ____ Skin Cancer

NEUROLOGIC
84 ____ Weakness
85 ____ Twitching
86 ____ Tremors
87 ____ Headache
88 ____ Fainting
89 ____ Dizziness
90 ____ Convulsions
91 ____ Epilepsy
92 ____ Numbness/Tingling
93 ____ Arm/Leg Pain
94 ____ Mental Disorder

MEN ONLY
95 ____ Testicular Swelling/Pain
96 ____ Prostate Problems

ACCIDENTS/TRAUMA
97 ____ Motor Vehicle Accidents
98 ____ Other Trauma/Accidents

MUSCULOSKELETAL
99 ____ Neck Stiffness/Pain
100 ____ Pain Between Shoulders
101 ____ Low Back Pain
102 ____ Swollen Joints
103 ____ Painful Joints
104 ____ Muscle Aches/Soreness
105 ____ Spinal Curvature
106 ____ Arthritis

CHILDHOOD DISEASES
107 ____ Mumps
108 ____ Measles
109 ____ Chicken Pox

HOSPITALIZATIONS
110 ____ List Dates and Reasons:

SURGERIES
111 ____ List Dates and Reasons:

MEDICATIONS
112 ____ Prescription
113 ____ Non-prescription

NUTRITIONAL STATUS
114 ____ Describe your nutritional status:

115 ____ Nutritional Supplements:

116 ____ Herbs/Botanicals:

HABITS
117 ____ Smoking ____ packs a day
118 ____ Drinking
119 ____ Recreational Drug Use

EXERCISE
120 ____ None
121 ____ 1-2 times a week
122 ____ 3-5 times a week
123 ____ 6-7 times a week

FAMILY HISTORY
124 ____ Diabetes
125 ____ Thyroid Disease/Goiter
126 ____ Tuberculosis
127 ____ Kidney Disease
128 ____ High Blood Pressure
129 ____ Heart Disease
130 ____ Cancer
131 ____ Muscle, Bone or Nerve Disease
132 ____ Other

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

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 as long as they are marked "Personal and Confidential."

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.

_____

Signature of Patient or Legal Guardian

_____

Date of Consent

_____

Print Name of Patient or Legal Guardian, if applicable

Authorization to Bill Insurance

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.

_____ Date _____

Signature of patient, parent or guardian