Health History

Last Name _____ First _____Middle In. _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____Work Phone (____)_____ Cell Phone (____) _____

E-mail Address:_____ Referred by _____

Occupation: _____ Age_____ Date of Birth _____/_____/_____ Sex _____ Weight_____

Social Security No. _____ Are you on Medicare? _____

If your condition due to an auto or work related accident ask receptionist for an "Accident Form"

If an accident are you suing anyone? _____ **If yes**, who are you suing? _____

SYMPTOMS: Check and Circle - Any boxes checked must be further explained on the following pages

Head:
- ❑ Headaches
- ❑ Migraines
- ❑ Dizziness / Light-headed
- ❑ Lights bother eyes
- ❑ Loss of balance
- ❑ Loss of memory
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Loss of hearing
- ❑ Pain in ears
- ❑ Ringing in ears
- ❑ Grinding of teeth
- ❑ TMJ - Jaw pain / clicking

Neck:
- ❑ Pain in neck
- ❑ Neck pain with movement
- ❑ Neck stiffness / tension
- ❑ Popping sounds in neck

Arms & Hands:
- ❑ Pain in upper arm (R - L)
- ❑ Pain in forearm (R - L)
- ❑ Pain in hand (R - L)
- ❑ Pins & needles in arm (R - L)
- ❑ Pins & needles in hand (R - L)
- ❑ Cold hands
- ❑ Swollen joints in fingers
- ❑ Loss of grip strength

Shoulders and Mid-back:
- ❑ Pain in shoulder joint (R - L)
- ❑ Pain across shoulder
- ❑ Cannot raise arm well
- ❑ Tension in shoulders
- ❑ Mid-back pain
- ❑ Pain between shoulder blades
- ❑ Muscle spasms

Chest
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Pain around ribs
- ❑ Heart Palpitations

Abdomen:
- ❑ Acid reflux/ Heart burn
- ❑ Nervous stomach
- ❑ Nausea
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea

Low back:
- ❑ Low back pain
- ❑ Low back pain is worse when:
  - ❑ Working
  - ❑ Lifting
  - ❑ Standing
  - ❑ Sitting
  - ❑ Bending / coughing
- ❑ Pinched nerve in low back
- ❑ Muscle spasms / tension

Hips, Legs, & Feet:
- ❑ Pain in buttocks (R - L)
- ❑ Pain in hip joint (R - L)
- ❑ Pain down leg (R - L)
- ❑ Knee pain (R - L)
- ❑ Pain in foot (R - L)
- ❑ Cramps in leg / feet (R - L)
- ❑ Pins & needles in leg (R - L)
- ❑ Pins & needles in foot (R - L)
- ❑ Swollen ankles / feet (R - L)
- ❑ Cold feet

General:
- ❑ Nervousness
- ❑ Irritable
- ❑ Depressed
- ❑ Fatigue / Lack of energy
- ❑ Loss of sleep
- ❑ Loss of weight

Woman Only:
- ❑ Menstrual pain
- ❑ Cramping
- ❑ Irregularity

Men Only:
- Impotence
- Prostate problems

Others:

- ❑ _____
- ❑ _____

For the previous symptoms checked please provide the following information:

a. **Date of initial onset** or **how long you have experienced this condition** (# of years, months, etc)?
b. **Frequency** or **how often it occurs** (constant, daily, weekly, etc)?
c. **Duration** or **length of time it usually lasts** (constant, minutes, hours, days, etc)?
d. **Intensity of the pain from 0 - 10** (0 = no pain, 10 = worse pain imaginable)
e. **Additional Comments**

Condition: _____

a. _____
b. _____
c. _____
d. _____
e. _____

Condition: _____

a. _____
b. _____
c. _____
d. _____
e. _____

Condition: _____

a. _____
b. _____
c. _____
d. _____
e. _____

Condition: _____

a. _____
b. _____

c. _____

d. _____

e. _____

Condition: _____

a. _____

b. _____

c. _____

d. _____

e. _____

Condition: _____

a. _____

b. _____

c. _____

d. _____

e. _____

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a. _____

b. _____

c. _____

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e. _____

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a. _____

b. _____

c. _____

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e. _____

Condition: _____

a. _____

b. _____

c. _____

d. _____

e. _____

Condition: _____

a. _____

b. _____

c. _____

d. _____

e. _____

Condition: _____

a. _____

b. _____

c. _____

d. _____

e. _____

Check any previously diagnosed condition

- ❑ Cancer
- ❑ Polio
- ❑ Tuberculosis
- ❑ High Blood Pressure
- ❑ Heart Trouble
- ❑ Diabetes
- ❑ Chronic Fatigue Syndrome
- ❑ German Measles
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Fibromyalgia
- ❑ Anemia
- ❑ Muscular Dystrophy
- ❑ Multiple Sclerosis
- ❑ Convulsions
- ❑ Epilepsy
- ❑ Concussion
- ❑ Arthritis
- ❑ Neuritis
- ❑ Rheumatoid Arthritis
- ❑ Depression
- ❑ Asthma
- ❑ Sinus trouble
- ❑ Guillan-Barre Syndrome
- ❑ Autism
- ❑ ADD/ADHD
- ❑ Herniated Disc
- ❑ Bulging Disc
- ❑ Sciatica
- ❑ Digestive Disorders
- ❑ Irritable Bowel Syndrome
- ❑ Hepatitis
- ❑ Other: _____
- ❑ Other: _____
- ❑ Other: _____

List any operations / surgeries and when performed

Surgery	**Date**
1	
2	
3	
4	
5	
6	

List any medications you are presently taking and the condition you are taking them for:

Medication	**Dosage**	**Condition**
1		
2		
3		
4		
5		
6		
7		
8		

Is it your desire to eliminate/reduce medication you are taking?	Yes /	No
Do you believe medication may be harmful to your health?	Yes /	No
Are you interested in nutritional support?	Yes /	No
Are you interested in fat loss?	Yes /	No
Are you interested in personalized fitness training?	Yes /	No

List emotional problem(s) and related treatments: _____

_____

Lifestyle

Exercise

How often do you get cardiovascular exercise?

4+ times per week 3 times per week 2 times per week once a week never

Select all cardiovascular exercise you do.

Running walking stair master swimming cycling aerobic other

Select how often do you work out with weights.

3 times per week 2 times per week once a week every other week never

List any contact sports you are involved in: _____

Nutrition

How often do you eat nutritious food?:

Every meal two times daily once a day every other day twice a week once a week never

How often do you drink coffee or caffeinated drinks

3+ per day two times daily once a day every other day twice a week once a week never

Family History

How long have you been married?_____

Were you previously married?_____ How long?_____

Have you been divorced or separated?_____

How many children from current marriage?_____ List names and ages

Name	Age	Name	Age
1_____	_____	4_____	_____
2_____	_____	5_____	_____
3_____	_____	6_____	_____

How many children from previous marriage?_____ List names and ages

Name	Age	Name	Age
1_____	_____	3_____	_____
2_____	_____	4_____	_____

How would you rate your relationship with your spouse, *10=best* (0 1 2 3 4 5 6 7 8 9 10)

How would you rate your relationship with your children, *10=best* (0 1 2 3 4 5 6 7 8 9 10)

Social

Select the ways you take care of yourself:

Church Synagogue Other Religious Instit. Meditation Yoga Crafts Outdoor Activ.

Others: _____

Specialists

Specialty	Name	Address	Phone number
Medical Doctor	_____	_____	_____
Gynecologist	_____	_____	_____
Dentist	_____	_____	_____
Chiropractor	_____	_____	_____
Trainer	_____	_____	_____
Nutritionist	_____	_____	_____
Physical Therapist	_____	_____	_____

Other Specialist

Type	Name	Address	Phone number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date_____**Signature**_____

Dr. J. R. Barone

www.baronespinalcare.com

937 N. Plum Grove Rd., Suite B
Schaumburg, IL 60173
Office: 847-619-7579 Fax: 847-619-6845

RULES AND REGULATIONS REGARDING

DIAGNOSTIC RADIOLOGY IN THIS OFFICE

(please sign where appropriate)

I, _____, authorize the performance of diagnostic x-ray examination of myself, which the above doctor may consider necessary or advisable in the course of my examination or treatment. I acknowledge that these X-rays are the sole property of Dr. Jeremy R. Barone and as such will be used exclusively for diagnostic purposes unique to the care of Dr. J. R. Barone.

Signed: _____

Date: _____

I, _____, authorize the performance of diagnostic x-ray examination of my child or ward, which the above doctor may consider necessary or advisable in the course of examination and treatment. I acknowledge that these X-rays are the sole property of Dr. Jeremy R. Barone and as such will be used exclusively for diagnostic purposes unique to the care of Dr. J. R. Barone. The patient is a minor of _____ years of age.

Signed: _____

Date: _____

VERIFICATION THAT YOU ARE NOT PREGNANT

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor has my permission to perform diagnostic x-ray examination. I have been advised that x-rays could be hazardous to an unborn child.

Date of last menstrual period: _____

Signed: _____

Date: _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's God-given ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or otherwise unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. *Our ONLY practice objective is to eliminate a major interference to the expression of the body's God-given wisdom. Our only method is specific adjusting to correct vertebral subluxations.*

I, _____, have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Patient Signature _____ Date : _____

Dr. J. R. Barone

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Disclosure for Use of First and Last Name

This office is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to the use of your name.

By way of signing this form, I release this office from all liability and authorize the use of my last name for the purpose of greeting me, announcing me into a room, or around the office in the presence of others. This is effective as of April 14, 2003 and remains in effect until further notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature **Date**

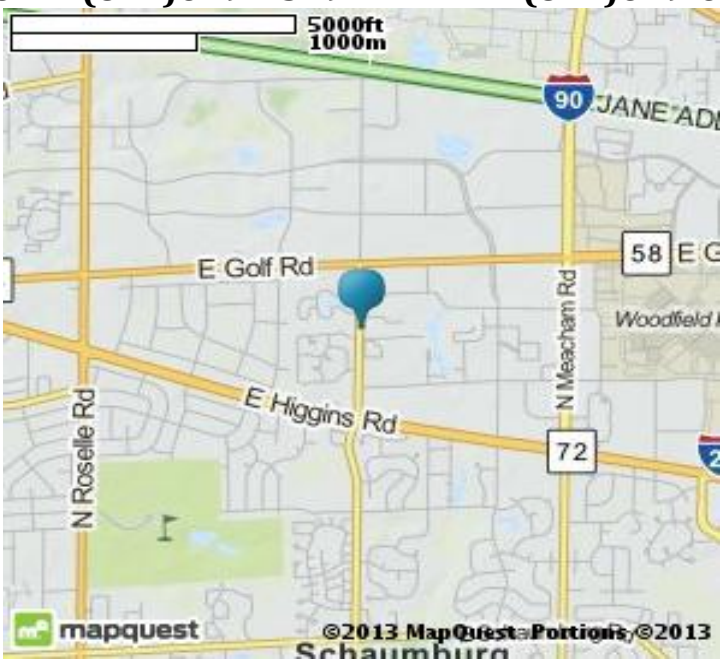
_____ _____
Authorized Facility Signature **Date**

Cancellation Policy for Consultations

Due to the length of time that the doctor sets aside for consultations, a $25 fee will be charged if a patient cancels or reschedules a consultation within 24 hours of the appointment. We appreciate your willingness to abide by the office guidelines so that we can best serve our patients.

Barone Spinal Care

937 North Plum Grove Road Suite B
Schaumburg, IL 60173
PHONE: (847)619-7579 FAX: (847)619-6845

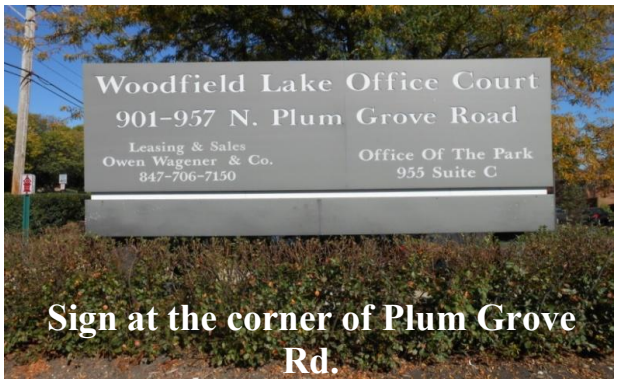


<u>Directions from Higgins Road.</u>

*Turn North onto Plum Grove Road.
*You will pass a light for Woodfield Road.
*On the right-hand side of the road you will see an office complex called **Woodfield Lake Office Court Buildings** 901-957 and a sign for Sonesta es Suites, turn down this road- **Woodfield Office Court**
*Turn into the 3rd parking lot on the left.
Building 937 will be directly in front of you, our front door is located at Suite B.

<u>Directions from Golf Road.</u>

*Turn South onto Plum Grove Road.
*On the Left hand side of the road you will see an office complex called **Woodfield Lake Office Court Buildings** 901-957 and a sign for Sonesta es Suites, turn down this road- **Woodfield Office Court**
*Turn into the 3rd parking lot on the left.
Building 937 will be directly in front of you, our front door is located at Suite B.



Sign at the corner of Plum Grove Rd.