

Health History

Address	ast Name First			Middle In Date		ate
Cocupation:	Address	City			State	Zip
Age	Home Phone ()	Work Phone ()	Cell Phone ()		
Four condition due to an auto or work related accident ask receptionist for an "Accident Form"	E-mail Address:			_ Refer	red by	
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:	Occupation:	Age	_ Date of Birth	_/	_/Sex	Weight
If yes, who are you suing? SYMPTOMS: Check and Circle - Any boxes checked must be further explained on the following pages	Social Security No		Are you on Medic	care? _		
Head: Headaches Pain in shoulder joint (R - L) Pain in hip joint (R - L) Pain in hip joint (R - L) Pain in houlder joint (R - L) Pain in hip piont (R - L) Pain hip piont (R - L) Pain hip piont (R - L) Pain hi	If your condition due to an auto o	r work related accident	ask receptionist for	or an "	Accident Form"	
Head:	If an accident are you suing anyone	? If yes , who a	are you suing?			
Headaches	SYMPTOMS: Check and Circ	le - Any boxes checked	d must be further e	explain	ed on the followi	ng pages
Headaches	Handi	Shoulders and Mi	d back:	Цiг	ne Lage 9 East:	
Migraines						D 1\
□ Dizziness / Light-headed □ Cannot raise arm well □ Pain down leg (R - L) □ Lights bother eyes □ Tension in shoulders □ Knee pain (R - L) □ Loss of balance □ Mid-back pain □ Pain in foot (R - L) □ Loss of memory □ Pain between shoulder blades □ Cramps in leg / feet (R - L) □ Loss of smell □ Muscle spasms □ Pins & needles in leg (R - L) □ Loss of smell □ Muscle spasms □ Pins & needles in leg (R - L) □ Loss of teate □ Pins & needles in foot (R - L) □ Loss of hearing □ Chest □ Swollen ankles / feet (R - L) □ Pain in ears □ Chest pain □ Cold feet □ Ringing in ears □ Shortness of breath □ Grinding of teeth □ Pain around ribs □ Nervousness □ TMJ - Jaw pain / clicking □ Heart Palpitations □ Nervousness □ TMJ - Jaw pain / clicking □ Heart Palpitations □ Nervousness □ Pain in neck □ Acid reflux/ Heart burn □ Patigue / Lack of energy □ Neck stiffness / tension □ Nausea □ Loss of sleep □ Neck stiffness / tension □ Nausea □ Loss of weight □ Popping sounds in neck □ Cas □ Constipation Woman Only: Men Only: □ Pain in upper arm (R - L) □ Pain in paper arm (R - L) □ Pain in forearm (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pins & needles in hand (R - L) □ Pan in fingers □ Standing □ Standing □ Prostate □ Pan in fingers □ Standing □ Standing □ Prostate □ Pan in fingers □ Pan in fi			• ,		,	,
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□ Loss of grip strength □ Sitting □ Sending / soughing		•		_		
□ Ponding / coughing		•				
	Loss of grip strongth	_	coughing	_		

Pinched nerve in low backMuscle spasms / tension

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:	
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Condition:	<u></u>
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Check any previously diagnosed condition

- F	Cancer Polio Tuberculosis High Blood Pressure Heart Trouble Diabetes Chronic Fatigue Syndrome German Measles Rheumatic Fever		Muscular Dystrophy Multiple Sclerosis Convulsions Epilepsy Concussion Arthritis Neuritis Rheumatoid Arthritis Depression Asthma			Autism ADD/ADHD Herniated Disc Bulging Disc Sciatica Digestive Disorders Irritable Bowel Syndrome Hepatitis Other:	
	⁻ ibromyalgia Anemia		Sinus trouble Guillan-Barre Syndro	me		Other:	
l iat amu		د م دارید	fa		_	Other.	
List any o Surgery	operations / surgeries and	wner	n perrormed Da	te			
3							
4 5							
45 6 List any i	medications you are prese	ntly t	aking and the condition	on you are			
45 6 List any i Medicatio	medications you are prese	ntly t	aking and the condition	on you are		ng them for:	
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List emotional problem(s) and related treatments:					
	Life	estyle			
Exercise		,			
How often do you get cardiovascular exercise?					
4+ times per week 3 times per week		week	once a week	never	
Select all cardiovascular exercise you do.	Z times per t	WOOK	once a week	Tievei	
Running walking stair master	swimming	cycling	aerobic	other	
Select how often do you work out with weights.	•	oyomig	acrosio	outor	
	once	e a week	every other w	eek never	
List any contact sports you are involved in:			•		
Nutrition					
How often do you eat nutritious food?:					
•	oneo a day		overy other day	twice a week	onco a wook
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 dr	inke				
3+ per day two times daily	once a day		every other day	twice a week	once a week
never	once a day		every officer day	twice a week	once a week
Family History					
Family History					
How long have you been married?			-		
Were you previously married?	•				
Have you been divorced or separated?					
How many children from current marriage?		_			Λ
Name 1	Age	Na 4			Age
2					
3		_			
How many children from previous marriage?					
Name	Age	Na	me		Age
1	_				_
2					
How would you rate your relationship with your spo					

<u>Social</u>

Select the ways	s you take care o	of yourself:				
Church	Synagogue	Other Religious Instit.	Meditation	Yoga	Crafts	Outdoor Activ.
Others:						
		S	pecialists			
Specialty	Name		Address			Phone number
Medical Doctor						
Gynecologist						
Dentist						
Chiropractor						
Trainer						
Nutritionist						
Physical Therap	ist					_
Other Specialis	t					
Туре	Name		Address			Phone number
	_					
	_					
	_					
Date	_Signature					



Dr. J. R. Barone



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) , 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: _____ , 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 p	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.

l,(print name)	_, have read and fully understand the above statements.
All questions regarding the doctor's objectives satisfaction.	pertaining to my care in this office have been answered to my complete
I therefore accept chiropractic care on this bas	is.
Patient Signature	Date :



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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



Directions from Higgins Road.

*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.

Directions from Golf Road.

*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.



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