

ABOUT THE PATIENT

Strong Roots Chiropractic LLC, 1926 S Main St. Eureka, IL 61530

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender ☐ M ☐ F
 Significant Other's Name _____ Kid's Names and Ages _____
 Your Employer _____ Type of Work _____
 e-Mail Address _____ Have you been to a chiropractor before? ☐ No ☐ Yes
 Emergency Contact _____ ph # _____
 Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Strong Roots Chiropractic LLC to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

Patient / Parent Signature _____

(This represents a long term authorization for all occasions of service)

Date _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
 2. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
 3. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
 4. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving
6. What makes it better? _____
7. What makes it worse? _____
8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

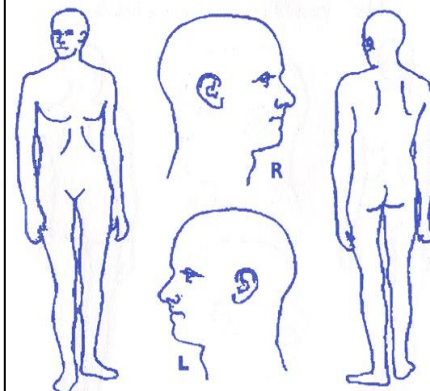
10. Results: _____

NOTES: _____

Are you pregnant?

☐ Yes ☐ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Strong Roots Chiropractic LLC 1926 S Main St. Eureka, IL

Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ Shortness of Breath
- ☐ ☐ Allergies / Asthma
- ☐ ☐ Medication Side Effects
- ☐ ☐ Diabetes
- ☐ ☐ Hands or Feet cold
- ☐ ☐ Muscle aches
- ☐ ☐ Trouble Walking
- ☐ ☐ Leg / Foot Numbness
- ☐ ☐ Fainting
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Ringing in Ears
- ☐ ☐ Ear Problems
- ☐ ☐ Sleeping Problems
- ☐ ☐ Vision Problems
- ☐ ☐ Thyroid Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Kidney Problems
- ☐ ☐ Light Bothers Eyes
- ☐ ☐ Other _____

Past Present

- ☐ ☐ Urinary Problems
- ☐ ☐ Easy Bruising
- ☐ ☐ Tobacco Use
- ☐ ☐ Dental Problems
- ☐ ☐ Fibromyalgia
- ☐ ☐ Blood Thinner use
- ☐ ☐ HIV Positive
- ☐ ☐ Cancer
- ☐ ☐ Depression
- ☐ ☐ Alcohol Use
- ☐ ☐ ___High or ___Low Blood Pressure
- ☐ ☐ Stroke History
- ☐ ☐ High Cholesterol
- ☐ ☐ TMJ
- ☐ ☐ Digestive Problems
- ☐ ☐ Pain all Over
- ☐ ☐ Tension / Irritability
- ☐ ☐ Chest Pains
- ☐ ☐ Heart Pacemaker
- ☐ ☐ Heart Problems

1. List any medications you are taking: _____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor": ☐ No ☐ Yes, Name _____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____

5. List any past work injuries: _____ Was any care received? _____

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

8. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Is there any other family history you want us to know? _____



1926 S Main St. Eureka, IL
Phone: (309) 466-2693

Patient Consent Form

Regarding the Use & Disclosure of Protected Health Information

For the purpose of this Consent Form, "Office" shall refer to: Strong Roots Chiropractic LLC

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or healthcare operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: _____



1926 S Main St. Eureka, IL
Phone: (309) 466-2693
Dr. Samuel A Hendricks

Acceptance of Agreement, Authorization to Release Information, and Assignment of Benefits

I have read this Agreement and understand that any treatment which has been or will be rendered by persons employed by **Strong Roots Chiropractic LLC** will be under the terms and conditions stated herein. I hereby authorize **Strong Roots Chiropractic LLC** to release any information acquired in the course of my examination or treatment. I hereby assign any benefits due me under my insurance plan to **Strong Roots Chiropractic LLC**.

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **Strong Roots Chiropractic LLC** any monies due him on my account, the same to be deducted from any settlement made on my behalf.

Further, I agree to pay **Strong Roots Chiropractic LLC** the difference, if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay **Strong Roots Chiropractic LLC** the full amount of his charges, should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim. Furthermore, I authorize **Strong Roots Chiropractic LLC** to furnish my attorney and/or insurance carrier medical information concerning my physical condition and treatment.

If all of your charges have not been paid within 30 days of our first statement, you must pay all of our expenses which we incur in connection with efforts to collect the charges. The expenses which you must pay include collection agency fees, attorney's fees, court costs, court reporter's fees, for depositions and at trial, and all other expenses we incur in enforcing our rights under this Agreement. Also in the event that you have not paid all charges due within 30 days of our first statement, a late charge will begin to accrue at the rate of one and one half percent per month.

Patient Name (please print): _____

Signature: _____ Date: _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell Number: _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____



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Phone: (309) 466-2693

Contact Preference

Is it okay for us to leave detailed voice messages on your home or cell phone? YES NO

Is it okay for us to contact you via email? YES NO

How did you hear about our office?

Friend

Family Member

Social Media

Other (_____)

Advertisement (_____)

Patient Name (please print): _____

Signature: _____ Date: _____

Insurance Release of Information

I consent Strong Roots Chiropractic LLC to release any medical information that may be necessary to process my insurance claim. I assign any benefits payable on my behalf to Strong Roots Chiropractic LLC. I assume financial responsibility for any balance that is not covered by my insurance.

Signature: _____ Date: _____

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner

OTHER COMMENTS: _____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner

OTHER COMMENTS: _____