CENTRAL ILLINOIS CHIROPRACTIC CENTER

Evidence-Based Treatment

731 Sabrina Dr.
East Peoria, IL 61611
Phone: 309-699-2422
Fax: 309-699-5399

2201 Eastland Dr, Suite 3
Bloomington, IL 61704
Phone: 309-808-0064

Website: www.ci-cc.com

Date: ____/____/____ Patient's Full Name _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

May we text your cell phone? ☐ Yes ☐ No If Yes, provide cell phone carrier: _____

☐ Male ☐ Female Age: _____ Date of Birth: ____/____/____ Social Security # _____-_____-_____

Mailing Address: _____ City: _____ State: _____ Zip: 61705

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children _____

Occupation: _____ Hours/Week _____ Employer: _____ Business Phone _____

Spouse's Name: _____ Employer: _____ Business Phone _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ City: _____ State: _____ Phone _____

Do You Have Health Insurance? _____ Company Name _____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Doctor's Name _____ City: _____ State: _____

Referred By (Friend, Relative, or Physician) : _____

Is Today's Visit Due to a Work Related Injury ☐ Auto Accident: ☐ Neither: ☐

Date Of Injury: _____

If yes to either a work related injury or auto accident, please check with receptionist, additional information is needed

Person Responsible for Account: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Method of Payment Preferred: ☐ Cash ☐ Check ☐ Credit Card

CENTRAL ILLINOIS CHIROPRACTIC CENTER

Evidence-Based Treatment

AGREEMENT, AUTHORIZATION, AND ASSIGNMENT

In consideration of Central Illinois Chiropractic Center's ("CICC") undertaking of chiropractic treatment services ("Services") for Patient ("I", "me", or "my"), I hereby agree as follows:

1. CICC is authorized to release any information it deems appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. Patient authorizes the direct payment to CICC of any sum Patient now or hereafter owes CICC by: (i) my attorney out of any settlement of litigation proceedings; and/or (ii) any insurance company obligated by contractual agreement to make payment to Patient or CICC based in whole or in part upon the charges incurred for the Services.
3. In the event any insurance company obligated by contractual agreement to make payment to Patient or CICC based in whole or in part upon the charges incurred for the Services refuses to make such payment upon demand by Patient, Patient hereby: (i) assigns and transfers to CICC any and all rights to a cause of action against any such insurance company (the name of the insurance provider and pertinent policy information shall be provided by Patient to CICC); and (ii) authorizes CICC to prosecute said action either in Patient's name, if deemed necessary in its discretion, and further authorizes CICC to compromise, settle, or otherwise resolve said claim solely in CICC's discretion. However, it is understood that Patient will make all reasonable efforts to collect the sums due from any insurance company obligated by contractual agreement.
4. Patient agrees and acknowledges that Patient is individually obligated to pay CICC any and all amounts Patient does not collect from any insurance company obligated by contractual agreement to make payment for Services rendered by CICC.
5. The covenants set forth in this Agreement shall be deemed to be a series of separate covenants. Should a determination be made by a court of competent jurisdiction that the scope of any covenant herein is unreasonable in light of the circumstances as they then exist, then it is the intention and agreement of the parties that the terms of this Agreement shall be modified and/or construed by the court in such a manner as to impose only those restrictions on Company which are reasonable in light of the circumstances as they then exist and as are necessary to assure the CICC of the intended benefit of this Agreement. The provisions of this Agreement shall be deemed severable, and the invalidity or unenforceability of any one or more of the conditions shall not affect the validity or enforceability of any one or more of the other remaining conditions herein.
6. Should CICC incur attorney fees, costs, and/or other expenses in order to enforce the terms of this Agreement, then Patient shall be liable for all reasonable attorney fees, costs, and expenses incurred by CICC. This Agreement shall be governed by and construed under applicable federal law and the laws of the State of Illinois. If there is any suit, claim, action, or proceeding arising out of or relating to this Agreement, the parties expressly agree that jurisdiction and venue shall be fixed in McLean County, Illinois.
7. Patient has carefully read and considered the provisions of this Agreement and, having done so, understands, acknowledges and agrees that: (i) Patient is familiar with the covenants set forth herein; and (ii) the remedies provided herein are fair and reasonable and are necessary for the protection of the CICC's interests.

Patient Signature_____ Date:____/____/____

CENTRAL ILLINOIS CHIROPRACTIC CENTER

Evidence-Based Treatment

Date:_____/_____/_____ Patient's Name: _____

Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Chief complaint_____ Secondary complaint(s) if any:_____
Date of Onset:_____ Was the Onset ☐ Gradual ☐ Sudden Since onset, has it gotten: ☐ Worse ☐ Better
Describe what caused the pain:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR CHIEF COMPLAINT:

Describe the quality of the complaint/pain:
- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ other:_____

Does any of the following make the pain worse:
- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ other:_____

Describe if pain is in a single spot or does is spread out:
- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ burning, sharp stabbing, tingling, numb
- ☐ other:_____

Does any of the following make it better:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ other:_____

How often are you aware of the pain:
- ☐ intermittent (less than 25% of time when awake)
- ☐ occasional (25-50% of time when awake)
- ☐ frequent (50-75% of time when awake)
- ☐ constant (75-100% of time when awake)

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:
☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No
If yes, explain;_____ Results:_____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

What type of care are you interested in (check all that apply):

☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health

---

Office Use Only:

NP1 NP2 NP3 NP4 OV1 OV2 A1 A2 A3 EM MED1 TE NMED ES M15 M30 MT XC3 XC5 XC7 XT2 XL2
NOTES_____
_____

CENTRAL ILLINOIS CHIROPRACTIC CENTER

Evidence-Based Treatment

Date:____/____/____ Patient's Name: _____

In general, would you say your health is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No
If yes, When: _____

Was treatment provided: ☐ Yes ☐ No
If yes, By whom: _____
Outcome: _____

2. Have you ever had a stroke or issues with blood clotting? ☐ Yes ☐ No

3. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries? ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

3. Are you presently taking any prescription drugs, over-the-counter drugs, vitamins, or supplements? ☐ Yes ☐ No

Product/Drug	Reason	Dosage	Frequency

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Please mark Y for yes or N for no for each of the following)

1. ____ Eyes
2. ____ Ears, Nose, Mouth, Throat
3. ____ Heart
4. ____ Lungs/ Breathing
5. ____ Intestines/Bowels
6. ____ Urinary
7. ____ Muscles
8. ____ Nerves
9. ____ Joints/Bones
10. ____ Skin
11. ____ Internal Organs
12. ____ Blood
13. ____ Allergies
14. ____ Psychological/Emotional

Females Only:

15. ____ Gynecological/Menstrual/Breast

Males Only:

16. ____ Prostate/Testicular/Penile

Please explain any above Yes answers: _____

SOCIAL HISTORY:
Recreational Activities (Hobbies): _____

Your education level: ☐ Highschool ☐ Some college ☐ College Graduate ☐ Post Graduate ☐ Other: _____

Yes	No		
☐	☐	Do you exercise? _____ times per week	
☐	☐	Do you smoke? _____ packs per day	If you have quit smoking, when did you quit? _____
☐	☐	Do you use other forms of tobacco?	What/How much per day? _____
☐	☐	Do you consume alcohol?	How many drinks per week? _____
☐	☐	Do you eat a balanced low fat diet?	If no, explain: _____
☐	☐	Do you get adequate sleep?	If no, explain: _____
☐	☐	Is work stressful to you?	If yes, explain: _____
☐	☐	Is family life stressful to you?	If yes, explain: _____
☐	☐	Do you use recreational drugs?	If yes, explain: _____

FAMILY HISTORY: list any diseases, disorders, or major illnesses. If deceased, from what?

1. Mother: _____
2. Father: _____
3. Sisters: _____ How many? _____
4. Brothers: _____ How many? _____
5. Other: _____

OTHER INFORMATION:

How do you sleep? ☐ Back ☐ Side ☐ Stomach

Do you use a pillow? ☐ Yes ☐ No

Do you wear orthotics or arch supports? ☐ Yes ☐ No

Females:

Date of last gynecological and breast exam: _____ Date of last menstrual cycle: _____

For X-Ray : Possible pregnancy? ☐ Yes ☐ No

Please read and sign:
I hereby state that all information that I have provided Central Illinois Chiropractic Center is complete and truthful and that I fully disclosed my health history.

SIGNED: _____ Date _____

Printed Name: _____

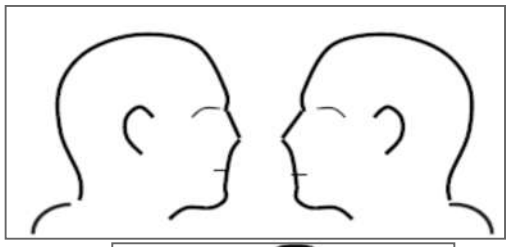
CENTRAL ILLINOIS CHIROPRACTIC CENTER

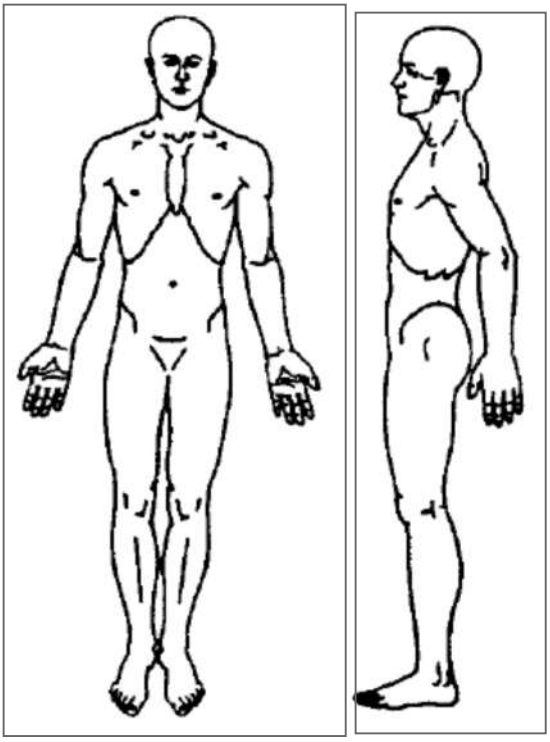
Evidence-Based Treatment

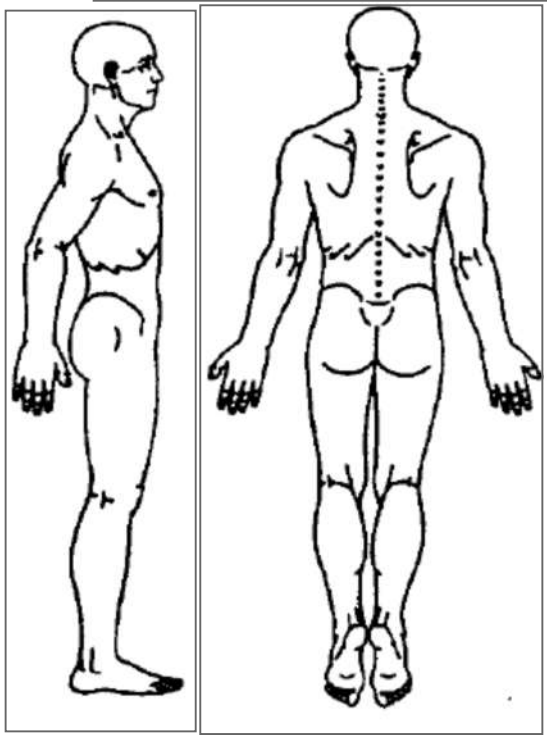
Date:____/____/____ Patient's Name: _____

Please Mark Area Of Pain on the Drawing Using The Codes Listed Below

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
===	Throbbing
000	Stabbing/Sharp



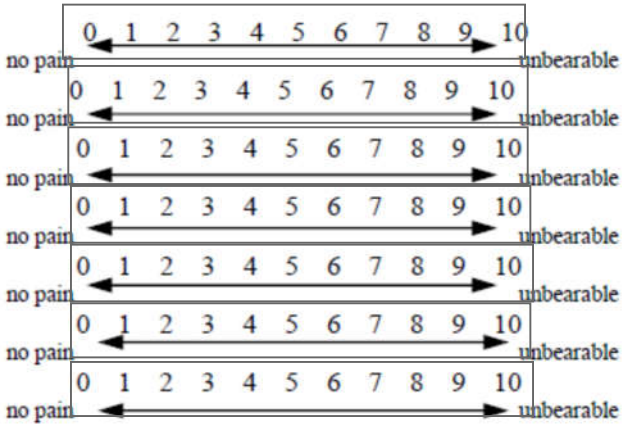




Example:

Ex.Complaint: low back pain

1. Complaint: _____
2. Complaint: _____
3. Complaint: _____
4. Complaint: _____
5. Complaint: _____
6. Complaint: _____



on

CENTRAL ILLINOIS CHIROPRACTIC CENTER

Evidence-Based Treatment

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor’s choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-thecounter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient Date_____

_____Signature of Parent or Guardian (if a minor) Date_____

_____Signature of Witness Date_____

CENTRAL ILLINOIS CHIROPRACTIC CENTER

Evidence-Based Treatment

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

There is a $20 charge for a cancellation or no-show without proper notice. This charge will not be covered by your insurance, but will have to be paid by you personally.

For Workmen's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

You may occasionally need to see another physician other than the one who normally sees you if you do need to re-arrange your appointment. All of our physicians are experienced professionals and they will study your chart. You may return to your original physician at the next appointment.

Please understand that your pain will probably increase and decreases as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason not to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt. 1) You, because you didn't get the treatment you need as prescribed by your doctor; 2) The doctor who now has a hole in their schedule; 3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter. We are looking forward to working with you.

Patient Signature:_____ Date:_____

Relationship to Patient if Patient is a minor:_____

CENTRAL ILLINOIS CHIROPRACTIC CENTER

Evidence-Based Treatment

AUTHORIZATION TO RELEASE RECORDS

Patient Name:_____

I authorize the release of a full report of examination findings, diagnoses, treatment program, etc., to any treating health care professional. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims.

I understand that I am personally responsible for all fees incurred as a result of treatment regardless of insurance coverage. In the event payment is not made and my account is referred to a collection agency , I will pay the costs of collection. If legal action is required, I will pay reasonable attorney's fees resulting from such action.

I give my permission for my diagnosis and treatment records to be used for purposes of research, education, or publication in professional journals.

Signed:_____ Date:_____

Relationship to Patient if Patient is a minor:_____

I authorize the following medical professional to release and send Dr. Michael Walz my medical records.

I further authorize you to accept a photocopy of this authorization, which photocopy may stand in lieu of the original thereof.

Pursuant to the Freedom of Information Act, you are also authorized to release the aforementioned records.

List physicians here _____

_____

_____

_____

Patient Signature:_____ Date:_____

Relationship to Patient if Patient is a minor:_____

Witnessed:_____ Date:_____

731 Sabrina Dr.
East Peoria, IL 61611
Phone: 309-699-2422
Fax: 309-699-5399

2201 Eastland Dr, Suite 3
Bloomington, IL 61704
Phone: 309-808-0064

Website: www.ci-cc.com