GURNEE WELLNESS GROUP

5101 Washington St., Suite #13 ■ Gurnee, IL 60031 ■ Office: 847.672.7920 ■ Fax: 847.672.7916

PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Date of birth : _____ / _____ / _____ Sex ☐ M ☐ F

Marital Status : ☐ M ☐ S ☐ W ☐ D

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

E-Mail: _____

Primary Care Physician: _____

Referring Physician: _____

EMERGENCY CONTACT INFORMATION

Name **Relationship** **Phone**

_____

RESPONSIBLE PARTY (If patient is un der 18 years of age)

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

PATIENT EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer: _____

Phone: (_____)_____ Occupation: _____

INSURANCE INFORMATION

☐ I do not have health insurance

Insurance Company: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber's Date of birth : _____ / _____ / _____

Relationship to Subscriber : _____ Subscriber's Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Is your visit a result of a motor vehicle / work accident? ☐ Yes ☐ No **(if yes, please inform the front desk)**

MEDICAL HISTORY (please check all that apply) ☐ None apply

- ☐ Heart attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Rheumatoid arthritis
- ☐ Peripheral neuropathy
- ☐ Peripheral vascular disease
- ☐ Coronary artery disease
- ☐ Bulging / Herniated disc
- ☐ Spinal stenosis
- ☐ *Cancer (please explain below)
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Lung Disease
- ☐ Blood vessel Disease
- ☐ Mental Illness
- ☐ Sleep apnea
- ☐ ADHD / ADD
- ☐ Gall Bladder Problems
- ☐ Other (please explain below)
- ☐ Gout
- ☐ Stomach Ulcer
- ☐ Kidney Stones
- ☐ Kidney failure
- ☐ Alcohol Dependence
- ☐ Pacemaker
- ☐ HIV Positive / AIDS
- ☐ Hepatitis
- ☐ Lupus
- ☐ Liver Problems
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hyperlipidemia
- ☐ Transplants
- ☐ Phlebitis
- ☐ Blood clots in legs
- ☐ Blood clots in lungs
- ☐ Insomnia
- ☐ GERD
- ☐ Loss of Memory
- ☐ Cold Hands / Feet
- ☐ Hand Tremors
- ☐ Epilepsy
- ☐ Stroke
- ☐ Diabetes

* Explanation: _____

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or office and authorize the office to furnish information regarding my illness to my insurance carrier. **I understand that I am responsible for any amount not paid by my insurance company.**

Patient Signature: _____ Date: _____ Account# :_____

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HISTORY OF PRESENT PROBLEM

Chief complaint: (why are you seeing the doctor today): _____

How long have you had this problem: _____ Has the pain ever been a level 9 or 10? ☐ Yes ☐ No

When do you feel it most? ☐ AM ☐ PM ☐ All Day How long does the complaint last? _____ Mins _____ Hrs

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

Does anything make your chief complaint worse? ☐ Yes ☐ No

If yes, please explain : _____

Does anything make your chief complaint better? ☐ Yes ☐ No

If yes, please explain : _____

Have you been treated previously for this condition? ☐ Yes ☐ No

Prior treatments for your chief complaint include: ☐ Chiropractic ☐ Physical Therapy ☐ Medical Doctor / Orthopedic

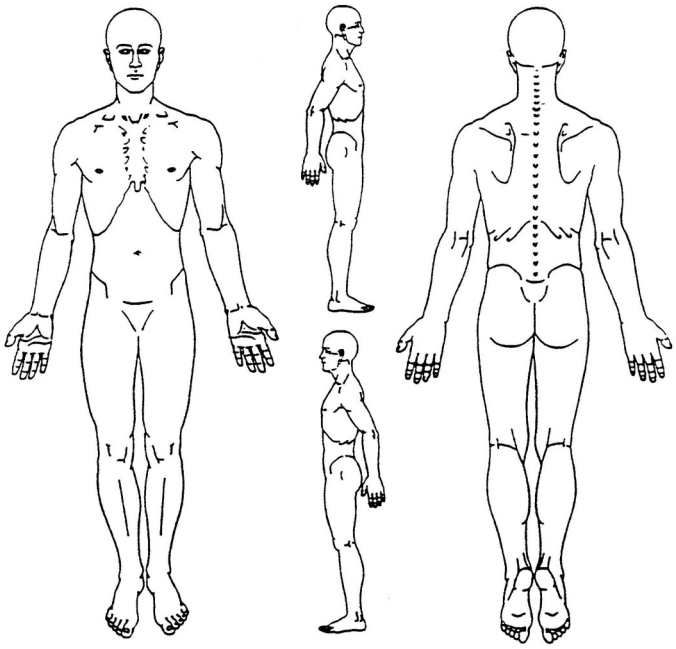
☐ Hospitalization ☐ Anti-Inflammatory ☐ Pain Medication ☐ Injection ☐ Heat/Ice ☐ Exercise ☐ Massage

☐ Other (please list) : _____

Please indicate the name of facility/physician and date of last visit: _____

On the diagram to the right, please indicate where you are experiencing your chief complaint by placing the letter(s) on the left on that specific area.

A: Ache **F:** Stiffness **T:** Tingling
B: Burning **N:** Numbness **X:** Sharp Pain
C: Cramping **R:** Throbbing
D: Dull Pain **S:** Soreness



Mark all activities that your chief complaint causes you to have trouble performing ? ☐ Standing ☐ Sitting

☐ Walking ☐ Running ☐ Bending ☐ Twisting

☐ Carrying objects ☐ Sleeping ☐ Driving ☐ Kneeling

☐ Lifting objects ☐ Lifting children ☐ Exercising

☐ Housework ☐ Personal Grooming

☐ Other : _____

Patient Name (please print): _____ Account # _____

Patient Signature _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

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Social History

Marital Status? ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have children? ☐ Yes ☐ No If yes, what are their ages: _____

Are you, or could you be, pregnant? ☐ Yes ☐ No

What was the first day of your last menstrual cycle? _____

Risk Factors

Do you smoke or use tobacco? ☐ Daily ☐ Occasionally ☐ Former ☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No If yes, indicate quantity: _____ drink per ☐ Day ☐ Week ☐ Month

Do you Exercise? ☐ Yes ☐ No What type?: _____ How many days per week? _____

Family History (check all that apply) ☐ None apply

Condition	Family Member (s)	Condition	Family Member(s)
☐ Heart disease	_____	☐ Scoliosis	_____
☐ Stroke	_____	☐ Spine problems	_____
☐ High Blood Pressure	_____	☐ Kidney failure	_____
☐ Diabetes	_____	☐ Mental illness	_____
☐ Osteoporosis	_____	☐ Bleeding disorders	_____
☐ Rheumatoid Arthritis	_____	☐ Anemia	_____
☐ Osteo Arthritis	_____	☐ Alcohol dependence	_____
☐ Lupus	_____	☐ Cancer	_____
☐ Sickle Cell	_____	☐ Other: _____	_____

Medications / Supplements you take ☐ None apply

Name	Dosage & Frequency	Who prescribed	Reason for taking

Patient Name (please print): _____ Account # _____

Patient Signature _____ Date: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED PLEASE REVIEW IT CAREFULLY.

Gurnee Wellness Group is committed to maintaining the privacy of your Protected Health Information known as PHI, which is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and the care and treatment you receive from our practice. In addition, the Notice describes your rights to access and control your PHI. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

We are 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 your protected health information.

Disclosure of Your Health Care Information

Treatment : We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment : We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation : We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Public Health : As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Agministration problems with products and reactions to medications, and reporting disease or infection exposure.

Additional Uses and Disclosures

Law Enforcement, National Security, Funeral Director, Organ Donation, Research, Public Safety.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Gurnee Wellness Group.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice. We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Dr. Brian Glaus, compliance officer, by calling this office at (847) 672-7920

Complaints

Complaints about your Privacy rights, or how Gurnee Wellness Group has handled your health information should be directed to Dr. Brian Glaus, compliance officer, by calling this office at (847) 672-7920. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to the appropriate Civil Rights office of Illinois.

This notice is effective as of January 1st, 2016. I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.