SCHUH
CHIROPRACTIC

Schuh Chiropractic LLC
108 South Wynstone Park Drive
Suite 102 North Barrington, IL 60010
P (224) 848-4588 F (224) 848-4585

Date:____

Name:____ Email: ________________________________

Home Phone:__________________________________ Cell Phone:__________________________________

Street Address: ____

City: ____ State: ______________ Zip: ____________________

Sex ☐ M ☐ F Birthdate:____________Age:_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

How did you hear about our practice? ____

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Injury/Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name:_________________________________Occupation:_______________ Address:____________________________Phone:______________ ☐ Full-time ☐ Part-time City: State: Zip:
SPOUSE	Name:____ Birthdate:____________________Age:____________ Employer Name:________________________________Occupation:___________________ Address:_______________________________________Phone:______________________ City: State: Zip:
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name:__________________________________ Policy/Group #:______________________________ Effective Date:____________________ Name of Insured:_____________________________ID #:____________________________
COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name:__________________________________ Policy/Group #:______________________________ Effective Date:____________________ Name of Insured:_____________________________ID #:____________________________
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ **Yes** ☐ **No** **Your Initials:**_________ If you answered **YES**, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician:____________________ **Person to contact in an emergency:**____ Relationship:______________________________Telephone:_________________________ Address:____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Schuh Chiropractic LLC. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. **I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.** I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. ______________________________________ ______________________ **Signature of Insured / Guardian** Date

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Condition Report

1. Primary complaint: ____

2. Is this injury due to: ☐ Work Injury ☐ Auto Injury ☐ Other __________

3. Date Problem Began: _________ Has it become: ☐Better ☐Worse ☐Same

4. What caused this problem? ____________________________________

5. Symptoms are worse (check all that apply): ☐ Morning ☐ Afternoon ☐Evening

6. The pain is:
   - ☐ Intermittent (1-25% of the time)
   - ☐ Occasional (26-50% of the time)
   - ☐ Frequent (51-75% of the time)
   - ☐ Constant (76-100% of the time)

7. What activities make this condition feel worse?

☐ Sleeping ☐ Walking ☐ Sitting ☐ Standing ☐ Bending
☐ Sports ☐ Lifting ☐ Push/Pull ☐ Running ☐ Coughing
☐ Sneezing ☐ Driving/Riding ☐ Change in Body Position
☐ Other ________________

8. What have you done to relieve this condition?

☐ Rest ☐ Sitting ☐ Standing ☐ Hot Pack ☐ Exercise
☐ Ice ☐ Stretching ☐ Lying Down ☐ Other ______________
☐ Medications/Drugs Please list Medication(s) ______________________

9. Please rate your pain on a scale from 0 to 10 (Please choose one number)

0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

10. How has your pain interfered with your daily activities (ADL'S)?

0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on activities

11. Have you seen any other doctor(s) for this condition? ☐ No ☐ Yes

*Please List doctor(s)*____

List of Surgery's/Hospitalizations *(Please include any metal implants or pace maker)*

Reason for Hospitalization/Operation	Date	Doctor/Hospital

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Previous Chiropractic Care:

☐ Yes ☐ No

Name of Dr. ______________________ Date of Last Visit: ______________________

Type of adjusting techniques used: ______________________

Please list any current prescriptions or vitamins being used:

____

____

____

Please mark below all areas of pain or injury on the illustrations below and give a word description of the symptoms you are experiencing in those areas.

Use the letters below to indicate the type and location of your sensations right now.

A= ACHE	B= BURNING	N= NUMBNESS
P= PINS & NEEDLES	S= SHARPNESS	T= TIGHT/STIFF
TH= THROBBING		SH= SHOOTING