Prairieland Wellness Center of McLean County
Craig A. Bowars DC, DCCN
1415 Croxton Ave, Bloomington, IL 61701
CONFIDENTIAL HEALTH INFORMATION

All information you supply is confidential.
We comply with all federal privacy standards.
(Please Print Clearly)

Name: _____ Gender: __ M __ F

Mailing Address:_____

City_____State_____ Zip Code_____

Birth Date: _____/____/_____ Age:_____

Marital Status: ___Single ____Married ____Separted ____Divorced ____Widowed ____Partnered

	May We Leave A Message?		Preferred method of contact?
Home Phone #:_____	**Yes**	**No**	**___Home Phone ___Cell Phone**
Cell Phone #: _____	**Yes**	**No**	**___Work Phone**
Work Phone #: _____	**Yes**	**No**	**Employer:_____**
E-Mail:_____	**Yes**	**No**	**Occupation:_____**

Emergency contact:_____

Relation to pt:_____ Phone _____

Primary Care Dr:_____

Whom may we thank for referring you to us?_____

Is there anyone you would like us to share your clinical Information with? ___NO ___YES

Names:_____

Is today's visit due to an auto accident or work-related injury? ___YES ___NO

If YES, please tell receptionist before completing paperwork

Do you have Medicare coverage? ___YES ___NO

If YES, we will need to copy your Medicare Cards & photo ID before you see the Dr.

Who is responsible for payment? _____ Relationship to patient? _____

Address: _____ Phone: _____

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment, or Prevention of Disease." A vitamin is not a drug. Neither is a mineral, a trace element, an amino acid, an herb, or homeopathic remedy. Although a vitamin, a mineral, a trace element, an amino acid, an herb, or a homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

_____ _____

Signature of patient/guardian **Date (MM/DD/YYY)**

Patient Name:_____ **DOB:**_____ **Date:**_____

1. Please list top 3 symptoms/concerns:

1)_____

2)_____

3)_____

2. And are the result of: ___An accident or injury: ___Work ___Auto ___Other

___A worsening long term problem

__An interest in: __Wellness __Other _____

3. Onset (When did you first notice your current symptoms?) _____

4. Intensity(On a 10 point scale with **zero being no pain**, and **10 being agonizing pain**, how extreme are your current symptoms?) _____

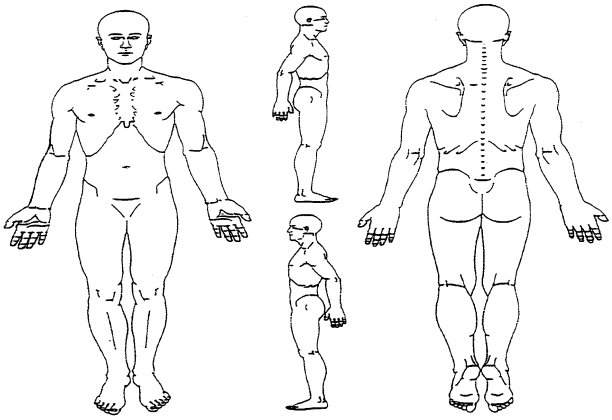
5. Duration & Timing (When did it start and how often do you feel it?) __Constant __Comes and goes How often?_____

6. Quality of symptoms (What does it feel like?)

__Numbness __Tingling __Stiffness __Dull __Aching __Cramps

__Nagging __Sharp __Burning __Shooting __Throbbing __Stabbing __Other _____

7. Where does it hurt? Mark the area(s) on the pictures below. **"O" for current conditions**. **"X" for past conditions.**



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

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9. Aggravation or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem?_____

What tends to lessen the problem?_____

10. Prior interventions (What have you done to relieve the symptoms?)

__Prescription medication __Over-the-counter drugs __Homeopathic remedies __Physical therapy __Surgery

__Chiropractic __Acupuncture __Massage __Ice __Heat __Other _____

11. What else shoud the Dr. know about your current condition?_____

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12. How does your current contition interfere with your:

Work or career:_____

Recreational activities:_____

Household responsibilities:_____

Personal relationships:_____

Patient Name:_____ DOB:_____Date:_____

13. Review of Systems

Using the point scale, rate each of the following symptoms based upon your typical health profile for the past 30 days:

Point Scale: **0 - *Never* or *almost never* have the symptom**
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD	____Headaches	
	____Faintness	
	____Dizziness	
	____Insomnia	***Total____***
EYES	____Watery or itchy eyes	
	____Swollen, reddened or sticky eyelids	
	____Bags or dark circles under eyes	
	____Blurred or tunnel vision (does not include near/far-sightedness)	***Total____***
EARS	____Itchy ears	
	____Earaches/infections	
	____Drainage from ear	
	____Ringing in ears, hearing loss	***Total____***
NOSE	____Stuffy nose	
	____Sinus problems	
	____Hay fever	
	____Sneezing attacks	
	____Excessive mucus formation	***Total____***
MOUTH/ THROAT	____Chronic coughing	
	____Gagging, frequent need to clear throat	
	____Sore throat, hoarseness, loss of voice	
	____Swollen or discolored tongue, gums, lips	
	____Canker sores	***Total____***
SKIN	____Acne	
	____Hives, rashes, dry skin	
	____Hair loss	
	____Flushing, hot flashes	
	____Excessive sweating	***Total____***
HEART	____Irregular or skipped hearbeat	
	____Rapid or pounding heartbeat	
	____Chest pain	***Total____***
LUNGS	____Chest congestion	
	____Asthma, bronchitis	
	____Shortness of breath	
	____Difficulty breathing	***Total____***
OTHER	____Frequent or urgent urination	
	____Genital itch or discharge	
	____Frequent illness	***Total____***

Digestive Tract	____Nausea,vomiting	
	____Diarrhea	
	____Constipation	
	____Bloating	
	____Belching, passing gas	
	____Intestinal/stomach pain	
	____Heartburn	***Total____***
Joints/Muscles	____Pain or aches in muscles	
	____Feeling of weakness/tiredness	
	____Stiffness or limitations of movement	
	____Pain or aches in joints	
	____Arthritis	***Total____***
WEIGHT	____Binge eating/drinking	
	____Craving certain foods	
	____Excessive weight	
	____Compulsive eating	
	____Water retention	
	____Underweight	***Total____***
ENERGY/ACTIVITY	____Fatigue,sluggishness	
	____Apathy, lethargy	
	____Hyperactivity	
	____Restlessness	***Total____***
MIND	____Poor memory	
	____Confusion,poor comprehension	
	____Poor concentration	
	____Difficulty in making decisions	
	____Stuttering or stammering	
	____Slurred speech	
	____Learning disabilities	***Total____***
EMOTIONS	____Mood swings	
	____Anxiety,fear,nervousness	
	____Anger, irritability, aggressiveness	
	____Depression	***Total____***
	GRAND TOTAL _____	

Patient Name:_____ **DOB:**_____ **Date:**_____

14. Your Medical History:

All known allergies:_____

Current medications:_____

Illnesses:_____

Surgeries:_____

Hospitalizations:_____

Family History

Do you have a family history of: ___Diabetes ___Cancer ___ Heart Disease ___High Blood Pressure

___Stroke ___Coronary Artery Disease ___Thyroid Disease ___ Rheumatoid Arthritis

Other_____

15. Social History

Marital Status: __Single __Married __ Partnered __Separated __Divorced __ Widowed

Use of Alcohol: ___Never ___No longer use ___History of alcohol abuse

Current Use - Type _____ ___ Rare ___Occasional ___Moderate ___Daily

Use of Tobacco: ___Never ___Quit – how long ago? _____ ___Smoke ____packs/day for ____ years

Do others depend upon you for their care? ____Children–age(s) _____ Pet(s)–what kind? _____

____ Elderly or disabled family member Other _____

Exercise: ___Never ___Rare ___Occasional ___Weekly ___Several times a week ___Daily

Types of exercise: _____

How much sleep do you average per night? _____hours

What is the type and approximate age of your mattress and pillow?_____

Acknowledgements

To set clear expectations, improve communication and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials_____ **I instruct the chiropractor to deliver the care that, in his professional judgement, can best help me in the restoration of my helath. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials_____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and on my behalf for seeking reimbursement from any involved third parties.**

Initials_____ **I grant permission to be called to confirm or reschedule an appointment.**

Initials_____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I will be asked to pay today for services and supplies received. I give permission to release information to my insurance company if requested.**

Initials_____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name:_____

_____ _____

Signature of patient/guardian Date (MM/DD/YYY)