

PrairieLand Wellness Center -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  Separated  Divorced  Widowed  Partnered

	May We Leave A Message?		Preferred method of contact?	
Home Phone #: _____	Yes	No	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone
Cell Phone #: _____	Yes	No	<div style="border: 1px solid black; padding: 5px;"><input type="checkbox"/> Work Phone</div>	
Work Phone #: _____	Yes	No		
E-Mail: _____	Yes	No	Employer: _____	Occupation: _____

Emergency contact: \_\_\_\_\_

Relation to pt: \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Dr: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Is there a family member or friend 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/YYYY)

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?) \_\_\_\_\_

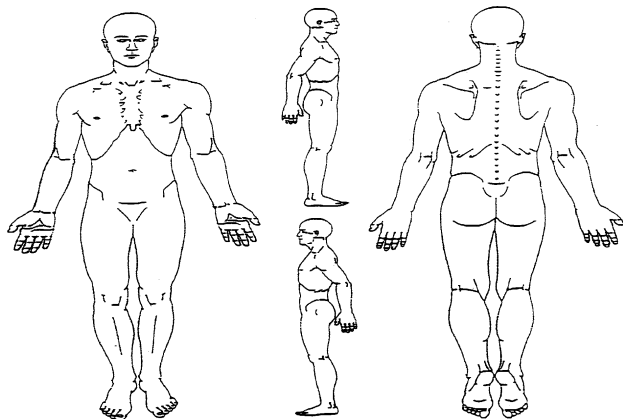
**4. Intensity**(On a 10 point scale with **zero being no pain**, and **10 being agonizing pain**, how extreme are your current symptoms?) \_\_\_\_\_

**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 should the Dr. know about your current condition?** \_\_\_\_\_

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**12. How does your current condition interfere with your:**

**Work or career:** \_\_\_\_\_

**Recreational activities:** \_\_\_\_\_

**Household responsibilities:** \_\_\_\_\_

**Personal relationships:** \_\_\_\_\_

Patient Name/DOB: \_\_\_\_\_

Date: \_\_\_\_\_

### 13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.

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*

<p><b>HEAD</b></p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Faintness</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Insomnia</p> <p style="text-align: right;"><i>Total</i> _____</p>	<p><b>Digestive Tract</b></p> <p><input type="checkbox"/> Nausea, vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Belching, passing gas</p> <p><input type="checkbox"/> Intestinal/stomach pain</p> <p><input type="checkbox"/> Heartburn</p> <p style="text-align: right;"><i>Total</i> _____</p>
<p><b>EYES</b></p> <p><input type="checkbox"/> Watery or itchy eyes</p> <p><input type="checkbox"/> Swollen, reddened or sticky eyelids</p> <p><input type="checkbox"/> Bags or dark circles under eyes</p> <p><input type="checkbox"/> Blurred or tunnel vision (does not include near/far-sightedness)</p> <p style="text-align: right;"><i>Total</i> _____</p>	<p><b>Joints/Muscles</b></p> <p><input type="checkbox"/> Pain or aches in muscles</p> <p><input type="checkbox"/> Feeling of weakness/tiredness</p> <p><input type="checkbox"/> Stiffness or limitations of movement</p> <p><input type="checkbox"/> Pain or aches in joints</p> <p><input type="checkbox"/> Arthritis</p> <p style="text-align: right;"><i>Total</i> _____</p>
<p><b>EARS</b></p> <p><input type="checkbox"/> Itchy ears</p> <p><input type="checkbox"/> Earaches/infections</p> <p><input type="checkbox"/> Drainage from ear</p> <p><input type="checkbox"/> Ringing in ears, hearing loss</p> <p style="text-align: right;"><i>Total</i> _____</p>	<p><b>WEIGHT</b></p> <p><input type="checkbox"/> Binge eating/drinking</p> <p><input type="checkbox"/> Craving certain foods</p> <p><input type="checkbox"/> Excessive weight</p> <p><input type="checkbox"/> Compulsive eating</p> <p><input type="checkbox"/> Water retention</p> <p><input type="checkbox"/> Underweight</p> <p style="text-align: right;"><i>Total</i> _____</p>
<p><b>NOSE</b></p> <p><input type="checkbox"/> Stuffy nose</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Sneezing attacks</p> <p><input type="checkbox"/> Excessive mucus formation</p> <p style="text-align: right;"><i>Total</i> _____</p>	<p><b>ENERGY/ACTIVITY</b></p> <p><input type="checkbox"/> Fatigue, sluggishness</p> <p><input type="checkbox"/> Apathy, lethargy</p> <p><input type="checkbox"/> Hyperactivity</p> <p><input type="checkbox"/> Restlessness</p> <p style="text-align: right;"><i>Total</i> _____</p>
<p><b>MOUTH/ THROAT</b></p> <p><input type="checkbox"/> Chronic coughing</p> <p><input type="checkbox"/> Gagging, frequent need to clear throat</p> <p><input type="checkbox"/> Sore throat, hoarseness, loss of voice</p> <p><input type="checkbox"/> Swollen or discolored tongue, gums, lips</p> <p><input type="checkbox"/> Canker sores</p> <p style="text-align: right;"><i>Total</i> _____</p>	<p><b>MIND</b></p> <p><input type="checkbox"/> Poor memory</p> <p><input type="checkbox"/> Confusion, poor comprehension</p> <p><input type="checkbox"/> Poor concentration</p> <p><input type="checkbox"/> Difficulty in making decisions</p> <p><input type="checkbox"/> Stuttering or stammering</p> <p><input type="checkbox"/> Slurred speech</p> <p><input type="checkbox"/> Learning disabilities</p> <p style="text-align: right;"><i>Total</i> _____</p>
<p><b>SKIN</b></p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Hives, rashes, dry skin</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Flushing, hot flashes</p> <p><input type="checkbox"/> Excessive sweating</p> <p style="text-align: right;"><i>Total</i> _____</p>	<p><b>EMOTIONS</b></p> <p><input type="checkbox"/> Mood swings</p> <p><input type="checkbox"/> Anxiety, fear, nervousness</p> <p><input type="checkbox"/> Anger, irritability, aggressiveness</p> <p><input type="checkbox"/> Depression</p> <p style="text-align: right;"><i>Total</i> _____</p>
<p><b>HEART</b></p> <p><input type="checkbox"/> Irregular or skipped heartbeat</p> <p><input type="checkbox"/> Rapid or pounding heartbeat</p> <p><input type="checkbox"/> Chest pain</p> <p style="text-align: right;"><i>Total</i> _____</p>	<p><b>GRAND TOTAL</b> _____</p>
<p><b>LUNGS</b></p> <p><input type="checkbox"/> Chest congestion</p> <p><input type="checkbox"/> Asthma, bronchitis</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Difficulty breathing</p> <p style="text-align: right;"><i>Total</i> _____</p>	
<p><b>OTHER</b></p> <p><input type="checkbox"/> Frequent or urgent urination</p> <p><input type="checkbox"/> Genital itch or discharge</p> <p><input type="checkbox"/> Frequent illness</p> <p style="text-align: right;"><i>Total</i> _____</p>	

Patient Name/DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**14. Your Medical History:**

All known allergies: \_\_\_\_\_

Current medications/what they are for: \_\_\_\_\_

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 health. 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 released 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/YYYY) \_\_\_\_\_