WELCOME

Progressive Health & Rehabilitation
1283 W. Dundee Road, Buffalo Grove, IL 60089
415 W. Golf Road, Suite 3, Arlington Heights, IL 60005

Patient Information

Today's Date: ___________________

Name: ____
Last First MI

Mailing Address: ____

____

Phone #: (H)__________________________ (C) ________________________ (W) ______________________

Can we call you at the above phone numbers and leave a message? ☐ Yes ☐ No
☐ Yes, except ______________________________

Date of Birth: ____________________________ SS#: ________________________ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Occupation: _________________________________ Employer: ____________________________________

Employer Address: ____ Phone: ____________________________

How did you hear about our practice? ____

Emergency contact: Name: ________________________________ Relationship: _________________________

Phone #: (H) ________________________ (C) _________________________ (W) ______________________

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other ____________

Has it been reported? ☐ Yes ☐ No If yes, to whom? ____

Financial Information

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S)

Name of person responsible for this account: ____

Relationship to patient (if other than self): ________________________ Phone # ______________________

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ________________________________

Do you have secondary/supplemental insurance? ❑ Yes ❑ No Name of Carrier: ___________________

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with ____________________and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Progressive Health and Rehabilitation, Ltd., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ____ **DATE** _________________________

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Health History

Please list all doctors currently involved in your care.

Doctor's Name	Phone #	Reason
1.		Primary Care Physician
2.		
3.		
4.		
5.		
6.		

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss	☐ Nausea
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs	☐ Depression	☐ Loss of Taste	☐ Cold Feet
☐ Arm/Hand Pain	☐ Fatigue	☐ Nervousness	☐ Loss of Memory	☐ Chest Pain
☐ Leg/Knee Pain	☐ Sleeping Difficulties	☐ Tension	☐ Jaw Problems	☐ Fever
☐ Headaches	☐ Loss of Smell	☐ Cold Sweats	☐ Constipation	☐ Fainting
☐ Dizziness	☐ Allergies	☐ Stomach Problems	☐ Shortness of Breath	
☐ Asthma	☐ Blurred Vision	☐ Night Pain	☐ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

☐ Aids/HIV	☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Stroke
☐ Alcoholism	☐ Cataracts	☐ Hernia	☐ Pacemaker	☐ Suicide Attempt
☐ Allergy Shots	☐ Chemical Dependency	☐ Herniated Disc	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Anemia	☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Tonsillitis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tuberculosis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Tumors/Growths
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Typhoid Fever
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Ulcers
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Psychiatric Care	☐ Vaginal Infections
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Venereal Disease
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	
	☐ Heart Disease	☐ Mumps	☐ Other ____________	

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain ______________

____

Please list any medications you are currently taking: ____________________

____

Please list any surgeries and/or hospitalizations you have had (type & date): ______________

____

Please list any allergies: ____________________

____

Please list any supplements you are currently taking (vitamins/herbs/minerals): ________________
____
____

Is there a family history of any of the following conditions? (Please indicate which family member, including parents, grandparents & siblings)

☐Heart Disease ______________________________ ☐Diabetes ___________________________

☐Cancer _____________________________________ ☐Arthritis ___________________________

☐ Other _____________________________________

Do you exercise: ☐Frequently ☐Moderately ☐Occasionally ☐None

Do your work activities mostly involve:
☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor

Do you sleep on your: ☐Back ☐Side ☐Stomach
Do you use a cervical pillow? ☐Yes ☐No

What is your daily/weekly intake of the following:

Caffeine ________ cups/day Alcohol ______ drinks/week Cigarettes _______ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) ____________________________________DATE ______________________

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NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME ____ **DATE** ____________

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: ____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: ____

3. Do your hands or arms fall asleep regularly? NO YES
   Comment: ____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: ____

5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: ____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: ____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: ____

8. Do our legs or feet fall asleep regularly? NO YES
   Comment: ____

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: ____

10. Do you suffer from cold hands or feet? NO YES
    Comment: ____

11. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication? ____
    ____

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12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind? ____
    ____

13. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for? ____________________________
    ____

14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it? ____
    ____

15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: ____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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Initial Symptom Checklist

Patient Name:____

Present Weight: ____

Allergy Test Date: ____

Checklist Date: ____

Medical Diagnosis (if any): _______________________________________

SYMPTOM POINT SCALE

Use the point scale to rate your symptoms based on how you've been feeling over the past 30 days.

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*

DIGESTIVE TRACT

_____ Belching
_____ Bloated feeling
_____ Constipation
_____ Diarrhea
_____ Nausea
_____ Passing gas
_____ Stomach pains
_____ Vomiting
_____ **Total**

EARS

_____ Drainage from ear
_____ Ear aches
_____ Ear infections
_____ Hearing loss
_____ Itchy ears
_____ Ringing in ears
_____ **Total**

EMOTIONS

_____ Aggressiveness
_____ Anxiety / Fear
_____ Depression
_____ Irritability / Anger
_____ Mood swings
_____ Nervousness
_____ **Total**

ENERGY / ACTIVITY

_____ Apathy
_____ Fatigue
_____ Hyperactivity
_____ Lethargy
_____ Restlessness
____ Sluggishness
____ **Total**

EYES

_____ Blurred vision
_____ Dark circles
_____ Sticky eyelids
_____ Itchy eyes
_____ Swollen eyelids
_____ Watery eyes
_____ **Total**

HEAD

_____ Dizziness
_____ Faintness
_____ Headaches
_____ Insomnia
_____ Lightheadedness
_____ **Total**

JOINTS & MUSCLES

_____ Aches in muscles
_____ Arthritis
_____ Feeling of weakness
_____ Limited movement
_____ Pain in joints
_____ Stiffness
_____ **Total**

LUNGS

_____ Asthma / Bronchitis
_____ Chest congestion
_____ Difficulty breathing
_____ Shortness of breath
_____ Wheezing
_____ **Total**

MIND

_____ Confusion
_____ Learning disabilities
_____ Poor concentration
_____ Poor memory
_____ Stuttering / Stammering
_____ **Total**

MOUTH & THROAT

_____ Canker sores
_____ Chronic coughing
_____ Gagging
_____ Often clear throat
_____ Sore throat
_____ Swollen tongue / lips / gums
_____ **Total**

NOSE

_____ Excessive mucous
_____ Hay fever
_____ Sinus problems
_____ Sneezing attacks
_____ Stuffy nose
_____ **Total**

SKIN

_____ Acne
_____ Dermatitis
_____ Eczema
_____ Excessive sweating
_____ Flushing / Hot flashes
_____ Hair loss
_____ Hives / Rashes
_____ Itching
_____ **Total**

WEIGHT

_____ Binge eating
_____ Compulsive eating
_____ Cravings
_____ Excessive weight
_____ Underweight
_____ Water retention
_____ **Total**

OTHER

_____ Anaphylactic reactions
_____ Chest pains
_____ Frequent illness
_____ Genital itch
_____ Irregular heartbeat
_____ Rapid heartbeat
_____ Urgent urination
_____ **Total**

___________ **GRAND TOTAL**

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

________________________________ ________________________
Patient's Signature Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ___________________________________

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____________________________
____
____

Date of last menstrual period: __________________

______________________________ ______________________
Patient's Signature Date

Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies, provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for insurance payment is a courtesy, and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problem arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. You authorize the release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues the check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. You understand that this office accepts MasterCard, Visa, Discover Card, personal checks and cash.
15. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
16. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

____ _______/_______/_______

Patient Signature or Responsible Party Date