PALATINE FAMILY CHIROPRACTIC
doing our best work behind your back

Dr. Adam Hutton, BS, DC, DAAMLP
Biomechanical Spine Specialist
Chiropractic Physician

216 W. Northwest Hwy.
Palatine, IL 60067
847.776.5101

REGISTRATION

Date: _____

Name: (Last)_____ (First)_____ (MI)_____
Phone: _____ (Cell / Home) Birth Date: _____/_____/_____

Street Address: _____

City/State/Zip Code: _____

Sex : □ M □ F Marital Status:□ Single □Married □ Widowed □ Divorced

Email: _____ Occupation: _____

Insured's Name: (Last)_____ (First)_____ (MI)_____
Patient Agreement:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. Adam Hutton all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

Who can we thank for referring you? _____
PRIMARY CARE PHYSICIAN: _____Phone #: _____

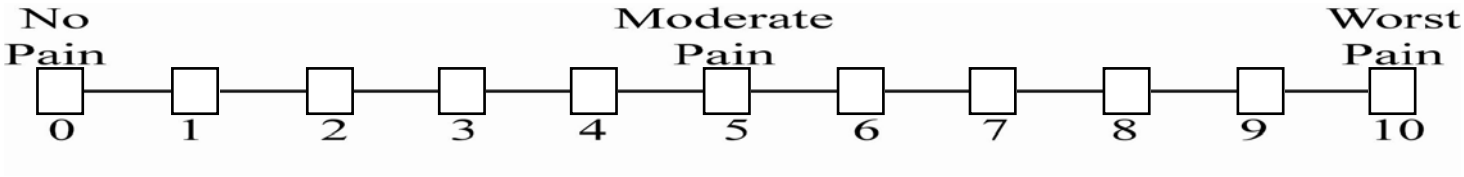
PRESENT COMPLAINTS (PLEASE CHECK THE APPROPRIATE ONES)

□ HEADACHE	□ FEET/HANDS COLD	□ UNBALANCED
□ MENTAL DULLNESS	□ DEPRESSION	□ FAINTING
□ LOSS OF MEMORY	□ RIB PAIN	□ BLURRED VISION
□ DIZZY	□ NERVOUSNESS	□ IRRITABILITY
□ EARS RINGING/BUZZING	□ EYE STRAIN/PAIN	□ DOUBLE VISION
□ UPPER BACK PAIN	□ SHORTNESS OF BREATH	□ LOSS OF SMELL
□ LOWER BACK PAIN	□ SHOULDER PAIN	□ CHEST PAIN
□ MIDBACK PAIN	□ CONFUSION	□ NECK PAIN
□ PINS AND NEEDLES IN HANDS □ RIGHT / □ LEFT	□ PINS AND NEEDLES IN ARMS □ RIGHT / □ LEFT	□ PINS AND NEEDLES IN LEGS □ RIGHT / □ LEFT

MEDICAL IMPLANTS: _____ MEDICAL ALERTS: _____

SURGICAL IMPLANTS: _____ PREGNANCY: □ YES □ NO

PAIN SCALE: Rate the severity of your pain by marking on the following scale.



Medications: (Please list all medications and supplements that you are currently taking)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: (Please list all medications that cause an allergic reaction)

_____ _____ _____

_____ _____ _____

_____ _____ _____

SMOKING: □ NO □ YES _____ PACKS PER DAY FOR _____ YEARS □ FORMER

ALCOHOL: □ NO □ YES _____ DRINKS PER WEEK □ FORMER

SURGICAL HISTORY: Please list ALL previous Surgeries and the date they were performed:

Surgery: _____ Date: _____

_____ _____

_____ _____

_____ _____

PERSONAL MEDICAL HISTORY & REVIEW OF SYSTEMS:

Please check any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** – No prior history of any significant medical problems

Lungs / Pulmonary – Breathing Disorders

□ Asthma □ Pulmonary Edema □Respiratory Arrest

□ COPD □ Pneumonia □ Sleep Apnea

□ Emphysema □ Tuberculosis

□ Other: _____

Cardiac / Heath and Peripheral Vascular Disease

□ Chest Pain / Angina □ High Blood Pressure □ Irregular Heartbeat

□ Mitral Valve Prolapse □ Deep Vein Thrombosis □ Bleeding Problems

□ Heart Attack, Myocardial Infarction □ Heart Murmur, Valve Disorder

□ Peripheral Vascular Disease □ Congestive Heart Failure

□ Other: _____

Neurologic Disorders

□ Stroke or Tia □ Parkinson's □ Cerebral Palsy

□ Peripheral Neuropathy □ Multiple Sclerosis, MS □ Polio

□ Other: _____

Bone and Joint Disorders

□ Osteoarthritis □ Gout □ Osteomyelitis

□ Rheumatoid Arthritis, RA □ Lupus □ Ankylosing Spondylitis

□ Other: _____

Gastrointestinal Disorders

□ Peptic Ulcer or Stomach Ulcer □ Diverticulitis □ Hepatitis – Type _____

□ Acid Reflux, GERD □ Irritable Bowel □ Liver Disease

□ GI Bleed □ Inflammatory Bowel Disease

□ Other: _____

Genitourinary Disorders

□ Urinary Tract Infection □ Kidney Problems □ Dialysis, Kidney Failure

□ Bladder Problems □ Kidney Stones

□ Other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ Skin Disorder _____ □ Depression

□ Thyroid Problems □ Psoriasis □ Anxiety

□ Sickle Cell Disease □ Any Skin Ulcer □ Alcohol or Drug Dependency

□ High Cholesterol or Lipids □ Tooth Abscess, Gingivitis

□ Other: _____

□ Cancer (any type) – please specify: _____

Other Medical Problems NOT included above (explain) _____

_____

_____

Family History:

Please check any significant family medical history or problems.

□ Asthma □ Tuberculosis □ Sleep Apnea □ COPD or Emphysema

□ Other Lung: _____

□ Heart Attack, Myocardial Infarction □ Congestive Heart Failure □ Irregular Heart Beat, Arrhythmia

□ Bleeding Problems □ Other Heart: _____

□ Peripheral Neuropathy □ MS or Parkinson's □ Other Neuro: _____

□ Osteoarthritis □ Lupus □ Gout □ Rheumatoid Arthritis

□ Other Bone & Joint: _____

□ Acid Reflux, GERD □ Inflammatory Bowel Disease □ Hepatitis – Type _____ □ Liver Disease

□ Other GI: _____

□ Kidney Problems □ Dialysis, Kidney Failure □ Diabetes □ Psoriasis

□ Thyroid Problems □ Sickle Cell Disease □ Any Skin Ulcer □ High Cholesterol or Lipids

□ Malignant Hyperthermia □ Cancer (any type) – please specify: _____

Other Medical Problems NOT included above (explain) _____

_____

_____

PATIENT PRIVACY NOTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your personal health information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you.

Permitted Disclosures:

1. Treatment Purposes – discussion with other health care providers involved in your care.
2. Inadvertent Disclosures – open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For Payment Purposes – to obtain payment from your insurance company or any other collateral source.
4. For Workers Compensation or Personal Injury Purposes – to process a claim or aid in investigation.
5. Emergency – in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or the general public.
7. To Government Agencies or Law Enforcement – to identify or locate suspect fugitive, material witness, or missing person.
8. For Military, national security, prisoner, and government benefits purposes.
9. Deceases Persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone Calls or Emails and Appointment Reminders – we may call your home and leave a message regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of Ownership – in the event this practice was ever sold the new owners would have access to your personal health information.

Your Rights:

1. To receive an Accounting of Disclosures
2. To receive a paper copy of the comprehensive "detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain issues and disclosures and with whom we release information to, although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To request amendments to information. However, like agreements, we are not required to agree to them.
6. To obtain one copy of your medical records at no charge when timely notice is provided (72 hours). X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made, we will be happy to accommodate you. However, you will be responsible for the cost.

Complaints:

If you wish to make a formal complaint about how we handle your health information, please contact our office directly.

I have received a copy of the Patient Privacy Notice. I understand my rights, as well as the office's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Patient Privacy Notice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this notice is available to me and copies are available at my request.

_____	_____	_____
(Print) Patient/Guardian's Name	(Signature) Patient Guardian's Name	Date
_____	_____	_____
(Print) Practice Representative's Name	(Signature) Practice Representative's Name	Date

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date