

# Patient Information

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

RACE \_\_\_\_\_ ETHNICITY \_\_\_\_\_

GENDER \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

Marital Status \_\_\_\_\_ Children \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured Birthdate \_\_\_\_\_

How did you find out about our office?  
\_\_\_\_\_

Is your condition due to an accident? \_\_\_\_\_ Date of your accident: \_\_\_\_\_

Please describe your current complaint. In other words, what brought you in to see us?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ASSIGNMENT OF BENEFITS -IRREVOCABLE-

In consideration of your undertaking to render care, I agree to the following:

### Release of Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

### Right to Receive Payment

I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney or any insurance company who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft or check containing my name to which you are legally entitled.

### Assignment of Right to Sue

1. In the event any insurance company or attorney, obligated by contractual agreement to issue payments to me for your service charges, refuses to pay upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
2. I also assign to you, the medical provider, and grant the right of lien against any and all claims against any third party, whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment.
3. I waive the Statue of Limitations regarding my doctor's right to recover from me directly
4. I hereby direct my attorney to cooperate, assist and not interfere with you, the medical provider, in recovering any MedPay benefits that I may be entitled to.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

MEDICAL PROVIDER: MARK J. GLESENER, DC



# Case History

Please answer the questions below concerning your health history. List all conditions or symptoms, both past and present. An understanding of your health history will help us to determine appropriate care.

NAME \_\_\_\_\_

DATE \_\_\_\_\_

## Review of Systems

1. Do you have skin, hair or nail problems?  Yes  No \_\_\_\_\_
  2. Do you have mouth and/or throat problems?  Yes  No \_\_\_\_\_
  3. Do you have nose and/or sinus problems?  Yes  No \_\_\_\_\_
  4. Do you have ear problems?  Yes  No \_\_\_\_\_
  5. Do you have eye problems?  Yes  No \_\_\_\_\_
  6. Do you have chest or lung (breathing) problems?  Yes  No \_\_\_\_\_
  7. Do you smoke?  Yes  No Amount per day \_\_\_\_\_ How Long? \_\_\_\_\_
  8. Do you have heart and/or blood vessel problems?  Yes  No \_\_\_\_\_
  9. Do you have blood or lymph node problems?  Yes  No \_\_\_\_\_
  10. Do you have digestive problems?  Yes  No \_\_\_\_\_
  11. Do you have genital problems (e.g. prostate, testicular, vaginal)?  Yes  No \_\_\_\_\_
  12. Do you have urinary (including kidney or bladder) problems?  Yes  No \_\_\_\_\_
  13. **Females**, have you had menstrual problems?  Yes  No \_\_\_\_\_
- Is there any chance that you are currently pregnant?  Yes  No \_\_\_\_\_
- Do you have any breast problems?  Yes  No \_\_\_\_\_
14. Do you have any nervous system diseases and/or mental health problems?  Yes  No \_\_\_\_\_
  15. Do you have any gland and/or hormone problems?  Yes  No \_\_\_\_\_
  16. Do you have allergy or immunity problems?  Yes  No \_\_\_\_\_
  17. Do you have any muscle, tendon or ligament problems?  Yes  No \_\_\_\_\_
  18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)?  Yes  No \_\_\_\_\_

## Past History

19. List any diseases which you have had in the past: \_\_\_\_\_  
\_\_\_\_\_
20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.:  
\_\_\_\_\_
21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?  Yes  No \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
22. List any major surgeries you have had:  
\_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_



# Case History

## (Continued)

NAME \_\_\_\_\_

DATE \_\_\_\_\_

23. Have you ever been hospitalized for any reason other than surgery?  Yes  No

24. Medications: Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: \_\_\_\_\_

25. Your diet is:  Balanced  Fair  Poor  Excessive  Restricted

### *Family History*

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)?  Yes  No \_\_\_\_\_

### *Social History*

27. In what position do you usually sleep, and how well? \_\_\_\_\_

28. Do you exercise on a regular basis?  Yes  No How? \_\_\_\_\_

29. How do you spend your spare time (hobbies, etc.)? \_\_\_\_\_

30. Do you use:  Caffeine?  Tobacco?  Nicotine?  Recreational Drugs?  Alcohol? \_\_\_\_\_

31. Please describe your work. \_\_\_\_\_

Type:  Professional  Physical Labor  Driver  Clerical  Factory  Homemaker

Physical Demands:  Heavy  Moderate  Mild  Sedentary

Stress Level:  High  Medium  Low

### *Additional Questions*

32. Do you have problems with recurring headaches?  Yes  No \_\_\_\_\_

33. Are you losing weight without trying?  Yes  No \_\_\_\_\_

34. Does your pain wake you up at night?  Yes  No \_\_\_\_\_

35. Have you had a change in bowel or bladder habits?  Yes  No \_\_\_\_\_

36. Have you had a sore that doesn't heal?  Yes  No \_\_\_\_\_

37. Have you recently had any unusual bleeding or discharge?  Yes  No \_\_\_\_\_

38. Do you have a thickening/lump in the breast or elsewhere?  Yes  No \_\_\_\_\_

39. Do you have indigestion or difficulty swallowing?  Yes  No \_\_\_\_\_

40. Have you had an obvious change in a wart or mole?  Yes  No \_\_\_\_\_

41. Do you have a nagging cough or hoarseness?  Yes  No \_\_\_\_\_

42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Fox Valley Chiropractic Physicians**  
**CONSENT TO CHIROPRACTIC EXAMINATION AND CARE**

PATIENT NAME:

DATE:

To the patient: As a patient, you are entitled to be informed the purpose, benefits, and potential risks of a health care procedure, and to make the decision about whether or not to undergo the procedure. Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

*The Nature of the Chiropractic Adjustment*

A primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy (also called "chiropractic adjustment"). If I believe it is indicated in your case, I will use this treatment by placing my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

*Other Examinations Tests and Treatments*

In addition, I may use other tests and examinations, some of which are listed below, if I believe they are warranted based on your condition and the information you give me. As a part of the analysis, examination, and treatment, you are consenting to the following procedures, except those that you mark below:

**Spinal Manipulative Therapy**

**Orthopedic Testing**

**Ultrasound**

**Graston**

**Extremity Adjustments**

**Basic Neurological**

**Hot/Cold Therapy**

**Manual Therapies**

**Accupuncture**

**Fascial Manipulation**

**Range of Motion Testing**

**Electrical muscle stimulation**

*Material Risks Of Chiropractic Adjustment*

As with any healthcare procedure, certain complications may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

*Probability of Risks Occurring*

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare. In 2008, one study reported the risk to be 1 case per 400,000 to 1,000,000 cervical spine adjustments. To the best of my knowledge, this is the largest controlled research study to date on this issue. Please ask if you would like additional information regarding cervical spine adjustments and risk of stroke. The other complications are also generally described as rare.

*Availability and Nature of Other Treatment Options*

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest - risks may include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers - typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.



- Surgery risk of adverse reaction to anesthesia, as well as an extended recovery period in a significant number of cases.

If you choose to use one of the above noted "other treatment" options, you should discuss their risks and benefits with your primary medical or osteopathic physician.

**Risks of Remaining Untreated**

Delay of treatment may allow formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. Therefore, delay of treatment may complicate the condition and make future rehabilitation more difficult.

Other Procedures and Risks: I have recommended that you undergo the following procedure (not listed above):

I have fully explained to you the risks and benefits of undergoing this procedure, as well as the risks and benefits of declining to undergo this procedure.

**For Parent or Guardian Signing Form on Behalf of Patients Under 18 Years of Age**

This office observes all laws regarding a minor patient's right to consent to, and to confidentiality of, his or her health care treatment. In addition, this office follows a policy of transitioning adolescent patients to self-management of their own health. We view our office visits as an opportunity for your child to learn to take responsibility for their health care. Therefore, as appropriate by age and maturity of the patient, parents may be asked to excuse themselves for a portion of or the entire health care visit. By signing this form, the parent or responsible party acknowledges understanding of and consent to this policy.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM.**

**PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW:**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment, as outlined in this document. I have discussed it with (insert doctor's name) and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks and benefits involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I understand that the doctor will use his or her best professional judgment but cannot and does not guarantee any outcome or results. Having been informed of the risks, I hereby give my consent to treatment as outlined in this document.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Responsible Party's Relationship to Patient

Glesener Chiropractic Center, PC  
DBA: Fox Valley Chiropractic Physicians

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Representative Signature

\_\_\_\_\_  
Signature of Patient

OR  
Signature of Responsible Party (Parent or Guardian)

\_\_\_\_\_  
Responsible Party's Relationship to Patient



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### *Assignment of Right to Sue*

1. In the event any insurance company or attorney, obligated by contractual agreement to issue payments to me for your service charges, refuses to pay upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
2. I also assign to you, the medical provider, and grant the right of lien against any and all claims against any third party, whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment.
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4. I hereby direct my attorney to cooperate, assist and not interfere with you, the medical provider, in recovering any MedPay benefits that I may be entitled to.

PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

MEDICAL PROVIDER: MARK J. GLESENER, DC



Glesener Chiropractic Center, P.C.  
1750 E. Main Street, Suite 60, St. Charles, IL 60174  
630-377-8844

## **ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE**

I have received a copy of this office's Notice of Privacy Practices.  
I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:  
Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.  
Obtain payment from third-party payers.  
Conduct normal health care operations such as quality assessments and accreditation.

Please click to download our Privacy Policy & HIPAA Notice

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Patient

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Signature

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Date

