**1767 West Ogden Ave., Ste. 143**
**Naperville, IL 60540**
**(630) 355-8988**

## Patient History

Name_____________________________________________SSN:_______________________Date__________________________
Address____________________________City___________________________________ State_________________ Zip__________
H. Phone (     )____________________ Cell Phone (      )______________________ Date of Birth___________ Age__________
E-mail____________________________________________How did you hear about us?___________________________________
Occupation________________________________________________Employer_____________________________________________
Marital Status S M D W Spouse's Name_________________________ Spouse Occupation ____________________
Number of Children ________ Children's Ages _________________________
Have you ever received Chiropractic Care? YES NO If yes, approximate date of last visit?____________________

1. **Primary reason for visit:**

2. **History:**

Surgeries or Hospitalizations? YES NO If Yes, please explain:

Work Injury? YES NO If Yes, please explain:

Auto Accident(s)? YES NO If Yes, please explain:

Sports Injury or Other? YES NO If Yes, please explain:

Broken Bones or Other Trauma? YES NO If Yes, please explain:

3. **Current Health Habits:**

Do you smoke? Pack per day? ___________ How many glasses of water do you drink per day? __________

Medications? YES NO If Yes, please write down which medications:

Exercise regularly? None Light_________ Moderate______________ Heavy______________

Do you have stress? Little Stress 1 2 3 4 5 6 7 8 9 10 Very Stressed

How many hours a day spent driving? ______ Hours

Hours of sleep per night? _______ Hours Sleeping Posture? Side Back Stomach

Are you pregnant? Y N; How many weeks?__________________________________________

**Symptoms and Present State of Health**

Pain or Problem started on______________________________________________

Pains are: Sharp Dull/ Ache Constant Intermittent Other______________

Does this pain shoot/ radiate/ travel in your body? Where?______________________________

Are you experiencing numbness or tingling in any area of your body? Where?____________________

Since it began, is it: Same Progressively Better Progressively Worst

What activities aggravate your condition/pain?______________________________

What activities lessen your condition/pain?______________________________

Is this condition worse during certain times of the day?______________________________

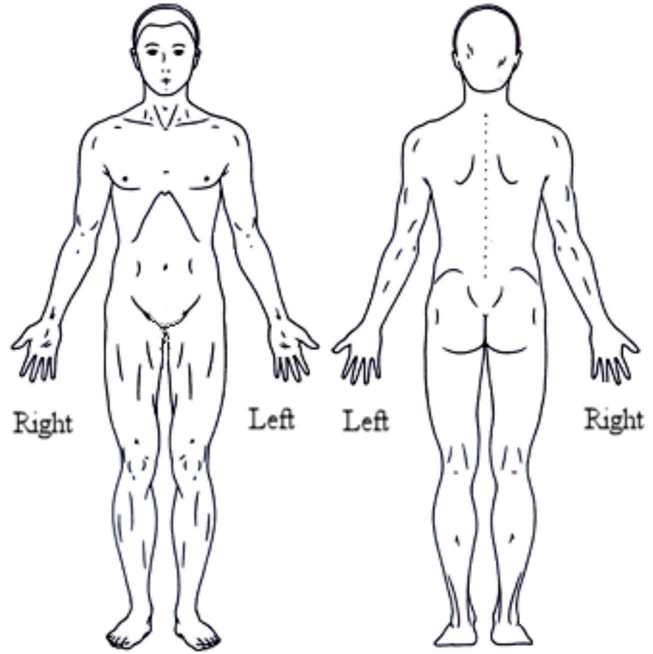
Is this condition interfering with: Work?________ Sleep?________Routine?______Other?______________

Other Doctors seen for this condition:______________________________

Any home remedies? ______________________________

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Using the symbols below, mark on the pictures where you feel pain.




| | |
|---|---|
| Numbness | = = = |
| Dull Ache | OOO |
| Burning | XXX |
| Sharp/Stabbing | / / / |
| Pins, Needles | + + + |
| Other ______ | ^ ^ ^ |

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

| | | | |
|---|---|---|---|
| O Headaches | O Pain in Hands or Arms | O Chest Pains | O Dental Problems |
| O Neck Pain | O Numbness in Hands or Arms | O Heart Attack | O Eye Problems |
| O Sleeping Problems | O Pain in Legs or Feet | O High Blood Pressure | O Hearing Problems |
| O Low Back Pain | O Numbness in Legs or Feet | O Stroke | O Other(s)__________ |
| O Nervousness | O Fatigue | O Cancer | |
| O Tension | O Depression | O Painful Urination | |
| O Irritability | O Lights Bother Eyes | O Diabetes | |
| O Dizziness | O Loss of Memory | O Diarrhea | |
| O Pain between Shoulders | O Shoulder Pain | O Constipation | |
| O Neck Stiff | O Sinus | O Stomach Upset | |
| O Joint Swelling | O Shortness of Breath | O Heartburn/Reflux | |
| O Fever | O Asthma | O Weight Loss | |
| O Loss of Balance | O Allergies | O Loss of Smell or Taste | |
| O Ringing in Ears | O Cold Hands | O Menstrual Cramps | |
| O Jaw/TMJ Problems | O Cold Feet | O Menopause | |

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature________________________________________Date____________________

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**Insurance Information:**

**Do you have health insurance? Yes □ No □ Auto Accident? Yes □ No □**

**Work Injury? Yes / No If yes, was it documented at work? Works Compensation # if known**______________________

**Advanced Health of Naperville will gladly accept most health and accident insurance plans and submit the necessary forms/claims required. I authorize payment of medical benefits to Advanced Health of Naperville and/or Dr. Cathy Subber. I authorize release of any medical or other information needed to process claims for services rendered. We will not release any information to any other party.**

**Patient Signature**_____________________________________ **Date**____________________

**Parent's Signature if patient is a minor**____________________________________________

**Cancellation Policy:**

At AHN, we are extremely mindful of valuing the time of each patient that walks through our doors. We only ask that you respect our time in return. Due to an increased number of patients not showing up for scheduled physical therapy sessions; there will be a cancellation policy. "No showing" for appointments not only affects us, but it also denies other patients the opportunity to benefit from the therapy. This change only affects people unwilling to notify us that they would be unable to show up for their scheduled service. We are always happy to help reschedule and/or cancel a scheduled appointment. **Please reschedule/cancel appointments 24 hours prior to your scheduled appointment time.** There will be $25 fee for "no showing" to either 30 minutes of physical therapy or a $40 fee for "no showing" to a 1 hour physical therapy. Please see front desk staff for more information.

Patient Signature _____________________________________ Date __________________

**Please acknowledge that you have received the Notice of Privacy Practices from Dr. Cathy Subber, D.C.**

Patient Signature _____________________________________ Date __________________