ADVANCED HEALTH of Naperville
"A New Experience in Chiropractic Care."

1767 West Ogden Ave., Ste. 153
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_____Referred by_____
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? 10 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?_____

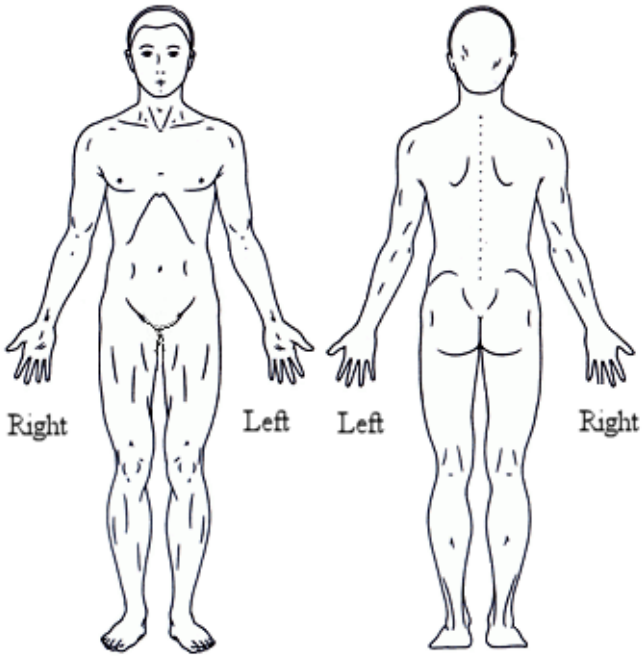
Is this condition interfering with: Work?_____ Sleep?_____Routine?_____Other?_____

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. 10



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 _____