Central DuPage Physical Medicine

798 W Army Trail Rd ■ Carol Stream, IL 60188 ■ Office: 630.233-8343 ■ Fax: 630.233.8346

PATIENT APPLICATION FOR TREATMENT

Date: _____

Name: _____ Date of birth : _____ / _____ / _____ ❑ Male ❑ Female

Address: _____ City: _____

State: ____ Zip: _____ SS# _____ ❑ M ❑ S ❑ W ❑ D Home: (_____)_____

# of Children _____ What are their ages? _____ Work: (_____)_____

Emergency contact: _____ Phone (_____)_____ Cell: (_____)_____

Employer: _____ Occupation: _____ E-Mail: _____

Satisfied with employment? ❑ Yes ❑ No Job disability in the last 12 months? ❑ Yes ❑ No

Have you ever had Chiropractic Care? ❑ Yes ❑ No If Yes, how long ago? _____

Do you exercise? ❑ Yes ❑ No If Yes, how often? _____ Type? _____

Chief complaint or reason for the office visit? _____

Ever been involved in a car accident? ❑ Yes ❑ No *** If Yes, please ask for our auto accident form. ***

Do you suffer from, been diagnosed as having, or currently have any of the following? **(circle Y or N for each)**

Y N *Broken / Fractured Bones	Y N Congenital Disease	Y N Epilepsy	Y N HIV Positive
Y N Circulatory Problems	Y N High Blood Pressure	Y N Pacemaker	Y N Tumors
Y N *Rheumatoid Arthritis	Y N Low Blood Pressure	Y N Insomnia	Y N *Cancer
Y N Seizures / Convulsions	Y N *Osteoarthritis	Y N Loss of Memory	Y N Strokes
Y N Dizziness/Fainting	Y N Gall Bladder Problems	Y N Cold Hands / Feet	Y N Hand Tremors
Y N Loss of Bladder Control			

* Explanation: _____

_____

Name of family medical doctor : _____ Forward your records to your doctor? ❑ Yes ❑ No

NAME OF MEDICATION / VITAMIN	DOSAGE	FREQUENCY	WHO PRESCRIBED	PURPOSE FOR TAKING

Central DuPage Physical Medicine is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____ Account# :_____