KAUFMAN WELLNESS CENTER, LTD.

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Ph: (309)670-2800 • Fax (309)670-2801

File # _____

ABOUT YOU

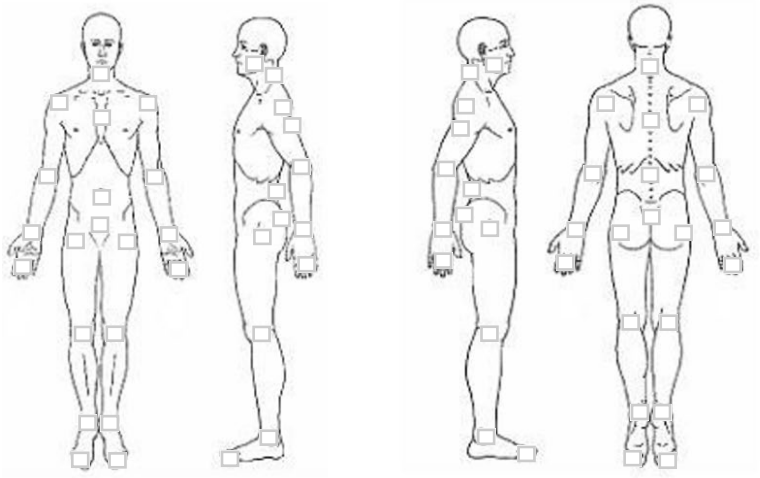
Name: _____ Preferred Name: _____ Date: ____/____/_____
Birthdate: ____/____/_____ Age _____ □ Male □ Female
Address: _____ City: _____ St _____ Zip _____
Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____
Email: _____ Appointment reminder preference: □ Text □ Email
Marital Status: □ Single □ Married □ Divorced □ Widowed
Employer: _____ Occupation: _____
□Full time □Part Time □Unemployed □Homemaker □Student □Light Duty □Disabled

Referred by: □Self-referred □Name of referring provider: _____
How did you find out about us? _____

REASON FOR VISIT

When did condition begin? ____/____/_____ (Please be specific on date).
Please describe the pain and its location: _____
_____
What caused your pain? □ Work □ Sports □ Auto □ Trauma □ Chronic □Fall □Gradual Onset
Explain what occured_____
What makes the pain worse? _____
What makes the pain better? _____
Is the condition getting worse? □ Yes □ No □ Constant □ Comes and Goes
Is the condition interfering with your: □ Work □ Sleep □ Daily Routine □Sports
Have you had this or a similar condition in the past? □ Yes □ No If yes, When: ____/____/_____
Did the condition get better? □ Yes □ No
Who is your Medical Doctor? _____ Phone: (_____) _____
Do you authorize us to discuss your medical condition with your Medical Doctor? □ Yes □ No
Are you seeing anyone else for this condition? Check all that apply and include the provider's name.

□ NONE □Chiropractor_____ □Cardiologist_____
□Neurologist_____ □Podiatrist_____ □Orthopedist_____
□Acupuncturist_____ □Massage Therapist_____ □Rheumatologist_____

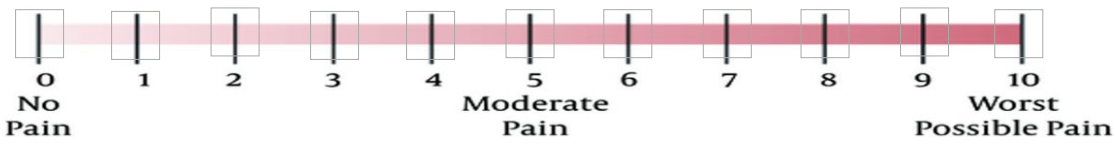


1. On the diagrams to the left, please **DRAW** where you are experiencing pain or other symptoms.

2. Then mark all areas with appropriate symbol(s) next to drawing.

Ache (AAA)
Burning (BBB)
Numbness (NNN)
Pins & Needles (PPP)
Stabbing (SSS)
Throbbing (TTT)
Other (OOO):_____

Please circle the number that best describes your pain



MEDICATIONS AND ALLERGIES

Please list them below OR bring a list to the front desk to be scanned in to your file.

Non-prescriptions: □No medications □Antihistamines □Decongestants □Herbal Supplement
□Advil/Aleve □Aspirin □Excedrin □Vitamins/Minerals
□Acetaminophen □Other _____

PRESCRIPTIONS:

1._____ Dosage: _____ **3. _____ Dosage: _____**
2._____ Dosage: _____ **4. _____ Dosage: _____**

SURGICAL HISTORY

1. _____ Date:_____ **4. _____ Date:_____**
2. _____ Date:_____ **5. _____ Date:_____**
3. _____ Date:_____ **6. _____ Date:_____**

MEDICAL HISTORY

Have you ever had any of the following diseases/Medical condition(s)?

□ Allergies	□ Cancer	□ Depression	□ Headaches	□ Incontinence	□ Parkinson's Disease
□ Anemia	□ Cardiac Conditions	□ Diabetes	□ Hearing Loss	□Kidney Problems	□ Rheumatoid Arthritis
□ Anxiety	□ Cardiac Pacemaker	□ Dizzy Spells	□ Hepatitis	□Metal Implants	□ Seizures
□ Arthritis	□ Chemical Dependency	□ Emphysema	□ Cholesterol	□MRSA	□ Smoking
□ Asthma	□ Circulation Problems	□Fibromyalgia	□ High/low	□Multiple Sclerosis	□ Speech Difficulty
□ Autoimmune	□Currently Pregnant	□ Fractures	Blood Pressure	□Muscular Disease	□ Strokes
Disorder	Due Date: _____	□ Gallbladder	□ HIV/AIDS	□Osteoporosis	□ Thyroid Disease
□ Chronic Pain (specify region):_____				□ Vision Problems	□ Tuberculosis

If yes to any above, please explain and/or add any other medical conditions_____

_____

ALLERGIES: _____

List any past serious accidents with date:_____

_____

DIAGNOSTIC TESTS/MEASURES (check all that apply *within the past year*):

□NONE	□Bronchoscopy	□EMG/Nerve conduction	□Stool Test
□Angiogram	□CT scan	□Mammogram	□Stress Test
□Arthroscopy	□Ultrasound	□MRI	□Urine Test
□Biopsy	□Echocardiogram	□Pap smear	□X-ray
□Blood test	□Electroencephalogram (EEG)	□Pulmonary Function Test	□_____
□Bone scan	□Electrocardiogram (EKG)	□Spinal tap	□_____

INSURANCE

Do you have Insurance? □ No □ Yes If yes, please give insurance card and ID to front desk to copy.
Name of Insurance: _____ Policy Holder: _____Policy Holder's DOB: ____/____/_____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual Understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the Business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collection your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also the provider and or managed care organization to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____/_____/_____