One Goal Wellness

PATIENT APPLICATION FOR TREATMENT

Name: _____ Date of birth: _____ Male Female

Address: _____ City: _____ State: ___ Zip: _____

SS# (if VA): _____ Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Email: _____ Emergency contact: _____ Phone: (____)_____

Employer: _____ Occupation: _____

Number of children: _____ Their ages: _____

Do you have health insurance?: Yes No Job disability within the last 12 months?: Yes No

Have you ever had chiropractic care?: Yes No If yes, how long ago?: _____

Who referred you to the office?: _____

Is your visit the result of an auto accident? Yes No ***If yes, please ask for auto accident form***

Is this work comp? Yes No ***If yes, please ask for work comp form and have information available***

Allergies?: _____

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 Medication/Vitamin	Dosage	Frequency	Who Prescribed	Purpose for Taking

One Goal Wellness 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. Your signature below acknowledges that you have been given an opportunity to read the Notice of Privacy Practices. You are also agreeing to payment and health care operations as the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Health History

1. What is your MAJOR COMPLAINT today? _____
2. WHEN did this episode begin? _____
3. HOW did this episode begin? _____
4. Is the pain getting better, worse, or staying the same? _____
5. Is the pain stopping you from doing any of your normal daily activities? YES NO If yes, please describe:

   _____
6. Are you pregnant or trying to get pregnant? YES NO How far along? _____
7. Have you had this pain/discomfort before? If yes, what treatment did you get? :

   _____
8. Is the pain CONSTANT FREQUENT or does it COME AND GO?
9. Does the pain radiate? YES NO If yes, where? Arm R/L Hand R/L Buttock R/L Leg R/L Foot R/L
10. WHEN is the pain worse: Morning Afternoon Evening Sleeping As day progresses No change
11. WHAT makes the pain worse? Walking Standing Sitting Bending Lifting Trying to stand up Driving Work Sports Sleeping Coughing Sneezing Laughing Other: _____
12. WHEN is the pain better: Morning Afternoon Evening Sleeping As day progresses No change
13. WHAT makes the pain BETTER? Ice Heat Stretches Sitting Lying Down Standing Walking Medication Chiropractic Other: _____
14. Do you have any weakness in your arms legs hands? YES NO
15. Do you have any recent changes in your bowel or bladder? YES NO
16. Are you RIGHT or LEFT handed?
17. Height: ___ft ___in Weight: _____lbs
18. List any major SURGERIES, major ILLNESSES, TRAUMAS, or FRACTURES

    BODY PART: _____ DATE: _____ BODY PART: _____ DATE: _____

    BODY PART: _____ DATE: _____ BODY PART: _____ DATE: _____
19. Please indicate illness on family history; Cancer, Diabetes, Stroke, Heart Condition, other:

    Mother: _____ Father: _____

    Sister: _____ Brother: _____

    Maternal Grandmother: _____ Maternal Grandfather: _____

    Paternal Grandmother: _____ Paternal Grandfather: _____
20. Marital Status: SINGLE MARRIED DIVORCED WIDOWED
21. Alcohol use: NONE CASUAL MODERATE HEAVY Type: BEER LIQUOR WINE
22. Caffeine use: NONE <3 CUPS/DAY 4-6 CUPS/DAY 6+ CUPS/DAY
23. Tobacco use: NONE FORMER SOCIALLY DAILY
24. Type of tobacco: SMOKE SMOKELESS VAPE
25. Exercise: NONE DAILY WEEKLY WALKS RUNS SWIMS WEIGHTS
26. Do you have any OTHER SYMPTOMS you would like to discuss at this time?

    _____

Patient Name: _____

Patient Signature: _____

Date: _____

One Goal Wellness

E&M Pain Drawing

Please circle the word that best describes your pain, and your level of pain with this condition/most recent episode.

0 being no pain, 10 being hospitalization.

Type of **neck** pain: Stiff Achy Burning Numb/Tingling Sharp Throbbing Pressure Spasms
Circle pain level: 0 1 2 3 4 5 6 7 8 9 10

Type of **shoulder** pain: Stiff Achy Burning Numb/Tingling Sharp Throbbing Pressure Spasms
Circle pain level: 0 1 2 3 4 5 6 7 8 9 10

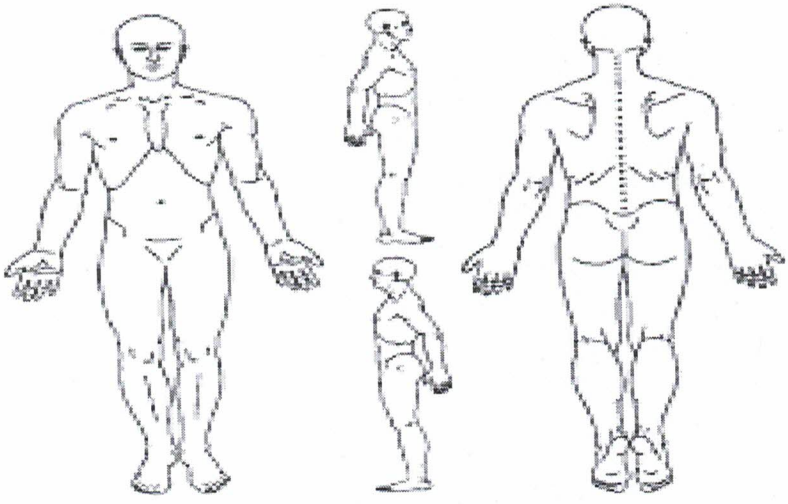
Type of **mid-back** pain: Stiff Achy Burning Numb/Tingling Sharp Throbbing Pressure Spasms
Circle pain level: 0 1 2 3 4 5 6 7 8 9 10

Type of **low-back** pain: Stiff Achy Burning Numb/Tingling Sharp Throbbing Pressure Spasms
Circle pain level: 0 1 2 3 4 5 6 7 8 9 10

Type of **hip/leg** pain: Stiff Achy Burning Numb/Tingling Sharp Throbbing Pressure Spasms
Circle pain level: 0 1 2 3 4 5 6 7 8 9 10

Type of **foot/ankle** pain: Stiff Achy Burning Numb/Tingling Sharp Throbbing Pressure Spasms
Circle pain level: 0 1 2 3 4 5 6 7 8 9 10

Mark areas of pain on figures below:



Patient name: _____

Patient Signature: _____ Date_____

One Goal Wellness

36735 N. Illinois 83, Ste D Lake Villa IL 60046 Office: 847-265-5600 Fax: 847-245-4491

WELCOME TO OUR OFFICE

We are committed to providing you with the best care possible and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures. We gladly accept Visa, MasterCard, Discover, American Express, check, and cash.

- **Limited Release of Medical Information:** I authorize One Goal Wellness to make inquiries and to release any pertinent information to any insurance company, adjuster, attorney, or government agency to facilitate collections/reimbursements under these assignments.
- **Insurance Patients:** I understand that my health insurance is a contract between myself, the insurance carrier and the provider. I understand that I am ultimately responsible for any fees for services rendered to me that does not get covered by my insurance company. I understand that this office accepts billing for individual or group policies, personal injury claims, authorized workers compensation, and Medicare.
- **Authorized to Process Drafts:** I agree that One Goal Wellness shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.
- **Assignment of Cause of Action:** In the event that any insurance company or third party obligated to make payment to me or to One Goal Wellness for the charges made for services rendered, refuses to make such payment upon demand, I hereby assign, transfer, and convey One Goal Wellness any and all cause of action that might exist is my favor against any such company or person. I authorize One Goal Wellness to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.
- **Collection/Attorney Fees:** I agree to pay all costs of a collection agency, if necessary, to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services rendered. I agree to pay reasonable attorney fees or other such costs as a court might deem proper.
- **Discounts and Promotions:** I agree that any discounts or promotions given to me applies if I agree to follow the full and complete treatment plan set forth by the doctor(s) of One Goal Wellness regardless if they are currently or formerly employed. In the event that I do not follow the treatment plan recommendations and I unilaterally remove myself from care, I agree and understand that any discount or promotion I have received will become null and void and I will be responsible for the complete balance in full less any payment made by me at the time of my unilateral discharge.

Patient Name (please print): _____

By signing below, you are indicating that you have read, understand, and agree to the above conditions of this office for the year 2021:

Patient Signature: _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

One Goal Wellness

36735 N. Illinois Rte 83, Suite D Lake Villa, IL 60046 Office: 847-265-5600 Fax: 847-245-4491

Informed Consent

I hereby request and consent to the performance (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic who now or in the future work at this office listed above. I will have opportunity to discuss with the doctors of the chiropractic practicing in this clinic and/or with other office or clinic personnel the nature and purpose of the procedures indicated above. I understand that results are not guaranteed if I consent to treatment.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interests.

I have read, or have had read to me, the above consent. I will have an opportunity to ask questions about its content, and by signing below, I am agreeing to the treatment recommendations that the doctor will lay out for me with the exception of the procedures I decline to undergo. By declining any of the procedures, I understand that the doctor may be working from limited information and that I understand and take full responsibility for the fact that this may affect the overall outcome of my care and possibly not reveal any potential abnormal findings that would be viewed or exposed with the use of further diagnostic investigation.

I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I see treatment at this office.

Patient Name (please print):_____

By signing below, you are indicating that you have read and understand and agree to the above conditions of this office.

Patient Signature: _____ Date:_____

Witness name (please print):_____

Witness signature:_____Date:_____