Lincoln Health & Wellness Center, Ltd. 5781 N. Lincoln Ave. Chicago, IL 60659

PATIENT INFORMATION **DATE ____ / ____ / ____**

Name (last, first) _____

Date of Birth: _____ Age: _____ Sex: M F

Marital Status (Circle one) Single Married Widowed Divorced Separated Domestic

Home Phone No. _____ Work No. _____ Mobile No. _____

E-mail Address: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Patient Employer: _____ Occupation: _____

Employer _____ City: _____ State: _____ Zip: _____

Note: Only fill out the following section if the patient is different than the insured.

Insured Name (last, first) _____ Date of Birth _____

Home Phone No. _____ Work No. _____ Mobile No. _____

Home Address: _____ City: _____ State: _____ Zip: _____

Insured's Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

REVIEW OF SYSTEMS (Please write in a number: 1 = presently have 2 = previously had)

GENERAL
- ____ Allergy (Seasonal)
- ____ Allergy (Food)
- ____ Chills
- ____ Convulsions
- ____ Dizziness
- ____ Fainting
- ____ Fatigue
- ____ Fever
- ____ Headaches
- ____ Migraines
- ____ Sleep loss
- ____ Weight loss
- ____ Weight gain
- ____ Nervousness
- ____ Depression
- ____ Neuralgia
- ____ Numbness
- ____ Sweats / Night sweats
- ____ Tremors/ Shaking

EYES, EARS, NOSE, THROAT
- ____ Asthma
- ____ Colds
- ____ Hoarseness
- ____ Sore throat
- ____ Hearing problems
- ____ Earache
- ____ Ringing in ear
- ____ Ear discharge
- ____ Sinus infection
- ____ Sinusitis
- ____ Nasal obstruction
- ____ Enlarged glands
- ____ Swollen lymph nodes
- ____ Enlarged thyroid
- ____ Nose bleeds
- ____ Poor vision

MUSCULOSKELETAL
- ____ Arthritis
- ____ Bursitis
- ____ Foot Trouble
- ____ Hernia (Inguinal)
- ____ Low Back Pain
- ____ Sciatica
- ____ Scoliosis
- ____ Poor Posture
- ____ Neck pain
- ____ Neck stiffness
- ____ Pain between shoulder blades

PAIN or NUMBNESS in
- ____ Shoulders
- ____ Arms
- ____ Elbow
- ____ Wrist
- ____ Hand
- ____ Finger(s)
- ____ Hip
- ____ Leg
- ____ Knee
- ____ Ankle
- ____ Foot
- ____ Toes
- ____ Tailbone

GENITO-URINARY
- ____ Bedwetting
- ____ Frequent Urination
- ____ Inability to control bladder
- ____ Painful urination
- ____ Blood in Urine
- ____ Kidney infection
- ____ Kidney stones
- ____

GENITO-URINARY (cont)
- ____ Prostate problem
- ____ Pelvic Inflammatory Disease
- ____ Painful Menstruation
- ____ Irreg. Menstruation

CARDIOVASCULAR
- ____ Stroke
- ____ Heart Attack
- ____ Heart Surgery
- ____ Abdominal Aortic Aneurysm
- ____ High blood pressure
- ____ Low blood pressure
- ____ Rapid heart beat
- ____ Slow heart beat
- ____ Pain over heart
- ____ Hardening of arteries
- ____ Poor circulation
- ____ Varicose veins
- ____ Ankle swelling

RESPIRATORY
- ____ Pulmonary Edema
- ____ Cough
- ____ Difficulty breathing
- ____ Wheezing
- ____ Bronchitis
- ____ Asthma
- ____ Emphysema / COPD
- ____ Chest pain
- ____ Spitting up blood
- ____ Spitting up phlegm

GASTROINTESTINAL
- ____ Belching/gas
- ____ Constipation
- ____ Reflux / GERD
- ____ Diarrhea

GASTROINTESTINAL (cont)
- ____ Indigestion/ Heartburn
- ____ Nausea/ Vomiting
- ____ Stomach pain
- ____ Poor appetite
- ____ Gallbladder problems
- ____ Liver trouble
- ____ Hepatitis
- ____ Jaundice
- ____ Hemorrhoids
- ____ Colon trouble
- ____ Irritable bowel
- ____ Colitis
- ____ Diverticulitis
- ____ Abdominal bloating
- ____ Celiac Disease

OTHER
- ____ Multiple Sclerosis
- ____ Rheumatoid Arthritis
- ____ Type 1 Diabetes
- ____ Type 2 Diabetes
- ____ Elevated Blood Glucose (Pre-diabetic)
- ____ Other Autoimmune Disorders
- ____ Cancer: Type_____
- ____ Metabolic Syndrome
- ____ Gout
- ____ Parkinson's

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Patient Name: _____ Date: _____

Current Medications: Please list the name and dosage, if possible. Include all vitamins, supplements, and other over the counter medications. (Continue on backside if needed)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergies: (Medications, foods, seasonal)

_____

_____

Date of your last physical exam/doctor visit and Results: _____

Family History							
	Arthritis	Cancer	Diabetes	Heart disease	Thyroid	Neurologic	Kidney
Father							
Mother							
Grandmother							
Grandfather							
Brother							
Sister							
DOCTOR ONLY:							

Hospitalizations/Surgeries *(Please list procedures, dates, and locations)*

_____

_____

Previous Injuries *(Sprains, fractures, auto or work injuries)*

_____

_____

Personal Habits – Please answer honestly. All information is confidential.

	NO	YES	How often?	Details
Smoke Tobacco				
Drink Alcohol				
Chew Tobacco				
Recreational Drugs				
Experience Stress				
Exercise Regularly				

Please indicate how many servings per day you consume:

___ Coffee	___ Water	___ Vegetables	___ Milk	___ Chicken	___ Fast Food
___ Tea	___ Diet pop	___ Whole Grains	___ Cheese	___ Red Meat	___ Processed Meats
___ Soft Drinks	___ Fruit Juice	___ Beans	___ Yogurt	___ Fish	___
___ Green Tea	___ Sports Drinks	___ Rice/Pasta/Potato	___ Fruit	___ Other Seafood	___

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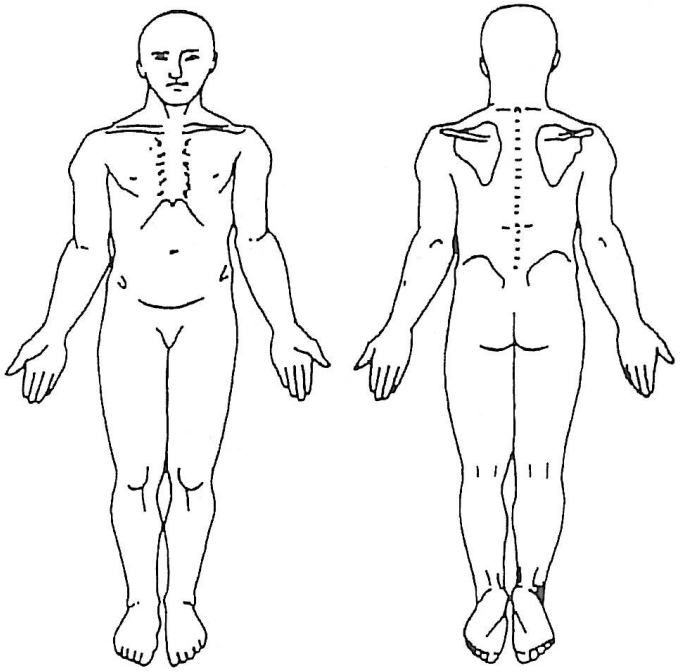
Patient Name: _____ Date: _____

Chief Complaint / History of Present Illness: Please describe your current problem/condition (use new form per condition)

Mark the areas on the diagram with the appropriate symbols for the sensation that you feel. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Sharp/ Stabbing
+++++	00000	xxxxx	*****	/ / / / /



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:

(1 = minimal; 10 = worst pain imaginable)

PAIN CURRENTLY

1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST

1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY

1 2 3 4 5 6 7 8 9 10

Doctor Only:

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Patient Name: _____ Date: _____

CHIEF COMPLAINT

Condition # (Use separate form for each condition) _____

1. Please describe the nature of your condition at this time _____
2. When did your condition first begin? _____
3. Cause of condition (Circle all that apply and explain)
   Auto accident Work injury Sudden trauma Reoccurrence Repetitive trauma Unknown/gradual Other
4. Have you had anything like this before? No / Yes When? _____
5. How often does the problem reoccur? _____
6. Is the pain (circle) Constant On & off usually lasting ___ minutes ___ hours __ days ___ weeks other ___
7. Lately has the pain been (circle) getting better getting worse staying about the same
8. Does the pain radiate? To where: _____
9. What makes it feel better? _____
10. What makes it feel worse? _____
11. If you have seen another professional for this problem, or done and self cares, describe the type of treatment and results: _____
12. At what time of day (AM, PM), or week (M-F/Wknd) is your pain worse? _____
13. In what setting (home recreation, work) is your pain worst? _____
14. Please list any activities you are unable to perform/have not performed due to the pain, or for fear of making the pain worse? _____
15. Has the condition limited any of the following activities? (Circle al that apply)
    Sleeping Walking Sitting Standing Climbing stairs Driving Eating Drinking
    Eating Drinking Self grooming Sexual intercourse Running Cycling Weight lifting Other exercise
16. Have you had chiropractic treatment in the past? If so, for which condition? Were you pleased with your results? Please explain: