PURE HEALTH AND VITALITY LLC
(847)230-0630
PureHealth.Vitality@gmail.com
27820 Irma Lee Circle Suite 1
Lake Forest , IL 60045

Confidential Intake Form

CONTACT INFORMATION

Last Name | **First Name**

Address | **City** | **State** | **Zip**

Email Address

Home Phone ( ) | **Work Phone** ( ) | **Cell Phone** ( )

Employer | **Position**

OTHER INFORMATION

Birthday (mm/dd/yy) / / | **Age** | **Gender** M / F | **Social Security Number** - - | **Driver's License #**

Referred by

GENERAL HEALTH INFORMATION

Height ' " | **Weight** lbs | **Adult Max.** lbs | **Adult Min.** lbs

PURPOSE(S) AND/OR HEALTH CONCERN(S)

Instructions: List the purpose(s) of this appointment and/or each major health concern you have.

1. _____
2. _____
3. _____
4. _____
5. _____

Current Health History

HEALTH CONCERN INFORMATION

Instructions: Fill out separate 'Current Health History' sheets for each health concern you listed above (there are multiple sheets provided for each). Mark the location of the concern or area pain on the diagram provided.

Purpose/Concern: _____

When did this begin? _____

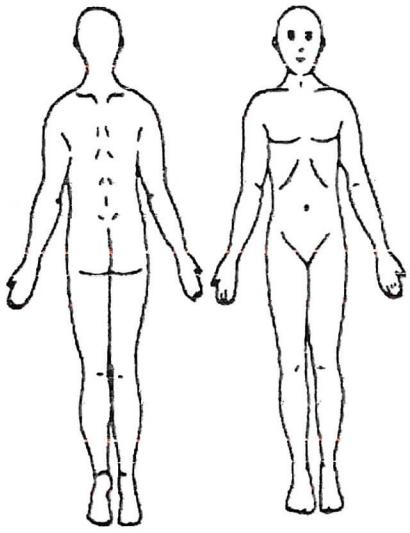
How (if known) did this begin? _____

Have you had this before? ❑No ❑Yes, when: _____

What makes this worse? _____

What makes this better? _____

Location of health concern



Circle the current intensity of this on a scale of 0 (no problem) to 10 (the worst): 0 1 2 3 4 5 6 7 8 9 10

Is this getting worse? ❑No ❑Yes ❑Comes and goes ❑It is constant

Is this worse at a certain time of day/month? _____

What does this prevent you from doing? _____

Did you see other doctors for this? ❑No ❑Yes, Dr.'s name(s): _____

Treatment: _____ Results: _____

Is this an accident related condition? ❑No ❑Work injury ❑Automobile injury ❑Other injury

NOTES

Pure Health and Vitality LLC◆666 Dundee Rd. Suite 1903 Northbrook IL 60062◆ Phone (847) 784-9156 ◆ Fax (847) 258-5588
PureHealth.Vitality@gmail.com

Past Health History – Page 1

PAST SURGERIES

Check any of the following surgeries you have had. Include approximate dates:

❑ Appendectomy_____ ❑ Tonsillectomy:_____ ❑ Gall Bladder:_____ ❑ Hernia:_____

❑ Back:_____ ❑ Neck:_____ ❑ Broken Bones:_____ ❑ Mastectomy: _____

List any others. Include approximate dates:

1. _____ Date: _____
2. _____ Date: _____

PAST DISEASES AND INFECTIONS

Check any of the following diseases or infections you have had:

❑ Pneumonia	❑ Mumps	❑ Influenza	**Notes:**
❑ Anemia	❑ Heart Disease	❑ High Blood Pressure	
❑ Measles	❑ Thyroid Disorder	❑ Eczema	
❑ Polio	❑ Chicken Pox	❑ Arthritis	
❑ Rheumatic Fever	❑ Small Pox	❑ Pleurisy	
❑ Tuberculosis	❑ Diabetes	❑ Epilepsy	
❑ Whooping Cough	❑ Cancer	❑ Mental Disorders	
❑ HIV +	❑ Hepatitis C	❑ High Cholesterol	

PAST TRAUMAS AND ACCIDENTS

List all previous traumas or accidents that might be related to your current health concern(s):

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

HOSPITALIZATIONS

List any/all previous hospitalization you have had, please include approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

ALLERGIES

List any known allergies you have: _____

HABITS AND SOCIAL HISTORY

Past Health History – Page 2

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS

Check any of the following that apply and describe the amount:

Intake	Quantity	Intake	Quantity
❑ Coffee		❑ Sugar/Starches	
❑ Tea		❑ Soft Drinks	
❑ Alcohol		❑ Fast Food	
❑ Cigarettes		❑ Meals/Day	
❑ Cigars		❑ Exercise	
❑ Other Tobacco		❑ Sleep	
❑ Recreational Drugs		❑ Other	

Medication	Dose/Frequency	Purpose	Medication	Dose/Frequency	Purpose
1.	/		11.	/	
2.	/		12.	/	
3.	/		13.	/	
4.	/		14.	/	
5.	/		15.	/	
6.	/		16.	/	
7.	/		17.	/	
8.	/		18.	/	
9.	/		19.	/	
10.	/		20.	/	

Instructions: Please indicate if any of the following family members have any disease(s), if they have passed on please indicate the cause of death and approximate age when they died.

FAMILY HISTORY
Father's Mother:
Father's Father:
Father's Grandparents:
Mother:
Mother's Mother:
Mother's Father:
Mother's Grandparents:
Mother's Siblings:
Your Siblings:
Your Children:

Past Health History – Page 3

REVIEW OF SYSTEMS

1. In the last year, have you experienced any of the following problems? Check all that apply:

- ❑ Eating Disorders
- ❑ Compulsivity (including compulsive eating)
- ❑ Increased hunger & weight gain after dieting
- ❑ Myoclonus (twitching muscles or legs)
- ❑ Depression
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Irritable Bowel Syndrome
- ❑ Migraine Headaches
- ❑ PMS
- ❑ Insomnia (sleep <4 hours per night with wake ups)
- ❑ Anorexia
- ❑ Bulimia
- ❑ Impulsivity
- ❑ Obsessionality
- ❑ Fibromyalgia
- ❑ Neurodermatitis
- ❑ Sleep Apnea
- ❑ TMJ Syndrome
- ❑ Bipolar Disorder
- ❑ Mania
- ❑ Aggression
- ❑ Self-Injury
- ❑ Chronic Pain States

FEMALE ONLY SECTION

Age of onset:_____ Are your periods regular? ❑Yes ❑No, explain:_____

_____

Your cycle is: _____ days (from start to finish). Menstrual flow: ❑Light ❑Medium ❑Heavy ❑Other: _____

Date of last period: _____ Do you take birth control pills or HRT? ❑No ❑Yes, what type:_____

Check all of the following premenstrual symptoms that apply:

❑ Anxiety	❑ Heavy Bleeding	❑ Bloating	❑ Depression	❑ Muscle Pains
❑ Irritability	❑ Prolonged Bleeding	❑ Breast Tenderness	❑ Headaches/Migraines	❑ Joint Pains
❑ Anger	❑ Clots	❑ Breast Enlargement	❑ Food Cravings	❑ Back Pain
❑ Agitation	❑ Water Retention	❑ Fibrocystic Breasts	❑ Sweet Cravings	❑ Acne
❑ Cramps	❑ Weight Gain	❑ Mood Swings	❑ Chocolate Cravings	❑ Foggy Thinking
❑ Fat Gain	❑ Cold Hands/Feet	❑ Blood Sugar Problems	❑ Irregular Periods	❑ Decreased Sex Drive
	❑	❑	❑	❑
❑ Gall Bladder	❑ Infertility	❑ Insomnia	❑ Osteoporosis	❑ Endometriosis
❑ Polycystic Ovaries	❑ Fibroids	❑ Cervical Dysplasia	❑ Autoimmune Disorder	❑ Cancer

MALE ONLY SECTION

Do you have a history of prostate problems? ❑No ❑Yes, explain: _____

List any additional male related changes/issues/concerns: _____

NOTES:

Natural Medicine Center Clinic Policies

NOTICE OF FINANCIAL RESPONSIBILITY

Pure Health and Vitality LLC is very pleased to have you as a new patient. We are honored you have selected our clinic for your care.

In many cases, your insurance will pay for part or all of chiropractic care or lab work of nutrition services. We will work with you to insure that you have all necessary documentation to file with your insurance carrier, motor vehicle insurer, or work related insurer, so they can process and pay your claims in a timely manner. However, our relationship is directly with you and not with your insurance company. You are receiving the services, and therefore you have the responsibility to pay for those services either at time of service or if other payment arrangement have been approved and signed.

If you are receiving treatment as a result of a motor vehicle accident, you are responsible for paying all costs for treatment not reimbursed by the Personal Injury Protection (PIP) coverage under a motor vehicle insurance policy or other insurance policy. If your motor claim is in dispute and there is no other insurance coverage for your treatments, we may agree to wait for payment until your legal case is settled or we may agree to accept regular monthly payments on your account. In any event, you are ultimately responsible for payment in full for services that you receive.

If it is necessary to initiate action to collect any unpaid balance on your account, you agree to pay reasonable costs of collection, including necessary attorney fees and court costs.

COLLECTION POLICY

The following collection policy applies:

1. The office collection policy is to collect full payment for the services rendered at the time of service.
2. MISSED APPOINTMENT: There will be a charge for appointments not cancelled 24 hours before the scheduled appointment. This charge is the amount of the actual appointment(s) missed.
3. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.
4. RETURN POLICY: 30 day return or exchange for any unopened non- expired nutrient or supply with a 3 % restocking fee. NO exception.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Pure Health and Vitality or its billing agent to releaase any information acquired in the course of my care to my insurance company or persons representing my case.

ACKNOWLEDGEMENT OF CLINIC POLICIES

My signature below is proof that I have read and understand the above policies for Pure Health and Vitality LLC.

Signature_____ **Date**_____