Illinois Valley Chronic Conditions & Acupuncture
Dr. Will Zuhira D.C.
4231 Progress Blvd. Suite #4 Peru, IL 61354

Application for Treatment

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: _____/_____/_____ Age: _____

Email Address: _____

Occupation (Current or Previous): _____ Retired: Yes □ No □

Spouse's Name: _____

Emergency Contact: _____ Emergency Phone: _____

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:
1)_____
2)_____
3)_____

List approximately how long you have noticed these problems:
1)_____
2)_____
3)_____

Is there a certain time of day any of these problems are better or worse?
_____
_____
_____
_____
_____

List the things you have used for these problems:
□Gabapentin/Neurontin □Lyrica □Cymbalta
□Physical Therapy □Pain Medications □Aleve
□Tylenol □Ibuprofen □Motrin □Chiropractic
□Massage Therapy □Injections □Acupuncture
□Creams on Hands/Feet
□Other Medications or Treatments:_____

Is your balance/walking ability affected? □Yes □No
If yes, please describe: _____
_____
What do <u>you</u> think is causing your problem? _____

Names of all doctors you have seen for these problems, types of doctors and treatment you received:

_____

_____

Have your symptoms: □Improved □Worsened □Stayed the Same

List anything that makes your condition worse: _____

List anything that makes your condition better: _____

_____

What are you hoping Dr. Zuhira will be able to do for you?_____

_____

How would you know that your treatment is complete? _____

_____

How would you describe your symptoms? Please check all that apply:

□Aching	□Numbness	□Hot Sensation	□Cramping
□Stabbing	□Tingling	□Nagging	□Swelling
□Sharp	□Pins and Needles	□Dead Feeling	□Stiff
□Burning	□Shooting	□Cold Hands/Feet	□Electric Shocks

Is this condition interfering with any of the following activities of daily living?

□Sleep □Work □Housework □Recreational Activities □Walking □Standing □Shopping

Current Pain Levels

DISREGARD THIS SECTION IF YOU ARE NOT EXPERIENCING PAIN

How would you rate your pain <u>RIGHT NOW</u>?

No Pain Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

What is your <u>TYPICAL or AVERAGE</u> pain level?

No Pain Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

What is your pain level <u>AT ITS BEST</u> ?

No Pain Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

What is your pain level <u>AT ITS WORST</u> ?

No Pain Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

If you had to accept some level of pain AFTER COMPLETION of treatment, what would be an acceptable level?

No Pain Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

How motivated are you in getting this condition resolved/handled?

Not Motivated Somewhat Motivated Extremely Motivated

0 1 2 3 4 5 6 7 8 9 10

Is there anything else you would like the doctor to know : _____

Health History

Are you allergic to any medications? □No □Yes If yes, please list: _____

List ALL Allergies (or Sensitivities) to Medicines, Foods, Scents, Latex and other items:

Item you react to	Reaction
_____	_____
_____	_____
_____	_____

Please list the prescription drugs you are currently taking, or attach list:

Prescription Name	Dose (MG or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Nutritional Supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History

Please check all that apply to you:

□ Diabetes Type _____	□ Osteoarthritis	□ Blood Clots	□ Brain Fog/Memory Problems
□ Foot Pain	□ Asthma/COPD	□ Peripheral Vascular Disease	
□ High Blood Pressure	□ Foot Numbness	□ Knee Pain	□ Plantar Fasciitis
□ Seizures	□ Sciatica	□ Spinal Stenosis	□ Trouble Sleeping
□ Hand Pain	□ Hand Numbness	□ Congestive Heart Failure	□ Bunion/Foot Surgery
□ High Cholesterol	□ High Blood Pressure	□ Thyroid Disorder	□ Pinched Nerve
□ Pacemaker	□ Low Back Pain	□ Headaches	□ Fatigue
□ Bulging/Herniated Disc	□ Frozen Shoulder	□ Chemotherapy	□ Joint Replacement(s)
□ Neck Pain	□ Rheumatoid Arthritis	□ Cancer	□ IBS/Crohn's/GERD

Other: _____

_____

ROS	(-)	Please check all **CURRENT** positive findings
Constitutional		Weight loss □ Fevers □ Chills □ Poor appetite □ Fatigue □ Weight gain □ Insomnia □ Night Sweats □
Eyes		Blurry Vision □ Eye Pain □ Eye Discharge □ Eye Redness □ Decrease in vision □ Dry Eyes □ Double Vision □
ENT		Sore Throat □ Hoarseness □ Ear Pain □ Hearing Loss □ Nose bleeds □ Tinnitus □ Sinus problems □
Cardiovascular		Chest pain □ Palpitations □ Rapid heart rate □ Poor circulation □ Swelling in the legs or feet □
Respiratory		Shortness of breath □ Chronic cough □ Coughing up blood □ Excess sputum production □
Gastrointestinal		Nausea □ Vomiting □ Diarrhea □ Constipation □ Frequent Heartburn □ Trouble swallowing □
Genitourinary		Increased urinary frequency □ Blood in the urine □ Incontinence □ Painful urination □ Urinary retention □
Skin		Rash □ Hives □ Hair loss □ Skin sores or ulcers □ Itching □ Skin thickening □ Nail Changes □
Musculoskeletal		Joint pain □ Muscle aches □ Frequent leg cramps □ Muscle weakness □ Bone pain □ Joint swelling □
Psychiatric		Anxiety □ Depression □ Alcohol or drug dependence □ Suicidal thoughts □ Panic attacks □
Endocrine		Goiter □ Heat intolerance □ Cold intolerance □ Increased thirst □ Excess sweating □
Neurological		Seizures □ Tremors □ Migraines □ Numbness □ Dizziness/Vertigo □ Loss of balance □ Slurred speech □
Hem/Lymphatic		Low blood count □ Easy bruising □ Transfusions □ Prolonged bleeding □ Blood clots □
Allergic/Immune		Allergic reactions □ Hay fever □ Frequent infections □ Hepatitis □ HIV positive □

Social History:

Non-Smoker (never smoked) □ Ex-Smoker □ Current Smoker □ How many packs per day? ____

Alcohol consumption: Never □ Occasional □ Frequent □

Family History: (Please list if a family member has/had the condition(s) you are seeing the doctor for)

Father: _____ Mother: _____

Grandparent: _____

Additional Information: Use this space to provide any additional information which may be important to your health care _____

_____

_____

_____

_____

_____ _____

Signature of Reviewing Physician Date Signature of Patient Date

Consent Agreement

Insurance Permission

As a courtesy to you, we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following statements or we cannot make claims directly to your insurance company:

Consent to Bill/Collect Insurance: I consent, if I am using a 3rd party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, parent/guardian, etc.) to allow Muscle Pain Clinic, Inc. DBA Illinois Valley Chronic Conditions (Dr. Will Zuhira, DC) to submit all necessary information needed to process my insurance claims. I authorize payment be made directly to Muscle Pain Clinic, Inc. DBA Illinois Valley Chronic Conditions. I permit a copy of this authorization to be used in place of the original.

_____	_____	_____	Patient/Guardian
Name	Patient/Guardian Signature	Date	(Circle)

Also, if you are <u>not</u> the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process.

Subscriber's name: _____ Subscriber's date of birth: _____

Consent to Examination and Treatment: I give the doctors and staff of Illinois Valley Chronic Conditions permission to perform all examinations and treatment deemed necessary by the doctor. I understand that some of these procedures may be performed by either staff or the doctor.

_____	_____	_____	Patient/Guardian
Name	Patient/Guardian Signature	Date	(Circle)

Consent to Retrieve Medical Records: I give Will Zuhira, DC and staff of Muscle Pain Clinic, Inc. DBA Illinois Valley Chronic Conditions permission to obtain any and all medical records from other providers, offices or hospitals which may assist with my care.

_____	_____	_____	Patient/Guardian
Name	Patient/Guardian Signature	Date	(Circle)

Pregnancy Waiver (Women Only): By my signature below, I am stating to the best of my knowledge I am not pregnant nor is pregnancy suspected at this time.

_____	_____	_____	Patient/Guardian
Name	Patient/Guardian Signature	Date	(Circle)

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Muscle Pain Clinic, Inc. DBA Illinois Valley Chronic Conditions to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below, you are giving us authorization to follow through with these procedures. Should you desire something not to be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voicemail at home or at work regarding appointments and other matters related to care in this office.
  If unable to reach me (please initial by your preference):
  [ ] you may leave a detailed message [ ] please leave me a message asking for a return call OR [ ] you may e-mail me at _____
- We acknowledge and thank everyone who refers friends or family members to our office. We would like to directly thank the person who referred you and use your name.
- When you refer anyone to us, we would like to directly thank you.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Illinois Valley Chronic Conditions. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization.

We at Muscle Pain Clinic, Inc. DBA Illinois Valley Chronic Conditions are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____	_____	_____
Name	Relationship	Phone Number

This **Release of Information** will remain in effect until terminated by me in writing.

I acknowledge that I have received a copy of Muscle Pain Clinic, Inc. DBA Illinois Valley Chronic Conditions *Notice of Privacy Practices for Protected Health Information.* Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

_____	_____	_____
Patient name	Patient Signature	Date