WELCOME

Thank You for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all of your needs, please fill out this form completely in ink. If you have any questions or need assistance, Please ask us- we will be Happy to Help You.

1 Personal Information

Date_____
Birthdate_____
Soc. Sec. #_____
Name_____
Wishes to be called_____
___ Male ___ Female ___ Single ___Married ___Divorced
Address_____
City, State, Zip_____
Employer_____ Occupation_____
Referred By_____

2 Responsible Party

Who is responsible for the account?
Name_____
Relationship to Patient_____
Birthdate_____ Driver license_____
Soc. Sec. #_____
Address_____
City, State, Zip_____
Employer_____ Occupation_____
Work Phone_____ Ext. _____
Home Phone_____

3 Telephone

Home Phone_____
Work Phone_____Ext. _____
Cell Phone_____
Where do you prefer to receive calls? ____ Home ____ Work ____ Cell
When is the best time to reach you? Time_____Days_____
In the event of an emergency, whom should we contact?
Name_____ Relationship_____ Work #_____ Home #_____

4 Authorization and Release

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me or to my child during the period of such care to third party payers and /or health practitioners, and financial agencies.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient or of minor Date

5 Financial Arrangements

I understand that my insurance company may require some services to be covered by me and I will be prompt to pay for those services provided by this office. I am aware that non-payment of those fees will be referred to a collection agency, which may negatively affect my credit standing. All fees for collection efforts will be billed to me.

X_____ _____

Signature of patient or of minor Date

□ Patient refused to sign

Thank you for filling these forms out completely. The information you have provided will help us to serve your healthcare needs more effectively. If you have any questions at anytime, Please ask-we are always **happy** to help.

PAST MEDICAL HISTORY

Please check any of the following conditions which you now have or have had in the past.

	YES	NO	WHEN DIAGNOSED
Diabetes	____	____	_____
Stroke	____	____	_____
Heart /chest pain	____	____	_____
High Blood Pressure	____	____	_____
Thyroid Disorder	____	____	_____
Emphysema	____	____	_____
Shortness of Breath	____	____	_____
Asthma	____	____	_____
Hepatitis/ Jaundice	____	____	_____
Kidney Problems	____	____	_____
Cancer	____	____	_____
Arthritis/ Back Pain	____	____	_____
Bleeding Problems	____	____	_____
Ulcer Disease	____	____	_____
Depression	____	____	_____
Fainting/Dizziness	____	____	_____
Seizures	____	____	_____
Chronic Pain	____	____	_____
Sports Injury	____	____	_____
Chronic Fatigue	____	____	_____
Lung Disease	____	____	_____
Sinus Problems	____	____	_____
Gastrointestinal Problems	____	____	_____
High Cholesterol	____	____	_____
Hormone Problems	____	____	_____
Recurrent Infections/Colds	____	____	_____
Chemical Sensitivity	____	____	_____

Other:

Past Surgical History:

_____

_____

_____

_____

Chief Complaint:

Main concern and its duration (How long have you had this problem/pain?):

Pervious or current treatment(s) (For your chief complaint/main concern)

How and where did the problem originate?

Exact location of problem or pain (ex. back, right or left leg, chest, etc)

Does the problem or pain affect other areas (ex. legs, arms, shoulders, etc.)?

Conditions that ease or worsen the problem or pain

Are you currently under the care of another physician or health professional?
List names and phone numbers, for what conditions and current treatment plan:

Do you have amalgam or dental work? Please describe:

_____
_____
_____

SOCIAL HISTORY

Sleeping Habits

Do you have problems sleeping? Yes_____ No_____
Average hours of sleep per night: _____ Do you snore? Yes_____ No_____
Do you feel rested when you wake up? Yes_____ No_____
Numbers of times you are awaken through the night: _____
Do you have trouble returning to sleep if awakened? Yes_____ No_____
List reasons for waking up (ex. short of breath, pain, stressed, urination, etc.)

_____
_____
_____

Eating Habits

Are you on a special diet? Yes____ No_____
If yes, please specify type of diet: _____
Describe your typical diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Other: _____

Lifestyle Assessment

Do you smoke? Yes____ No_____ Number of packs per day: _____
If yes, number of years: _____ Have you attempted to stop? Yes_____ No_____
Methods used to stop smoking_____
Have you ever smoked? Yes_____ No_____
Date last used/quit: _____
Do you drink alcohol? Yes_____ No_____ Frequency_____ Type_____
Have you felt you need to cut down on drinking? Yes_____ No_____
Have you been annoyed by criticism of drinking? Yes_____ No_____
Have you felt guilty about drinking? Yes_____ No_____
Do you drink in the morning? Yes_____ No_____

Recreational drug use (please specify, amount and frequency of use)

_____
_____
_____

Date last used _____

Do you consider yourself active? Yes_____ No_____

Please list activities you are involved in as well as frequency and duration:
(Ex. sports-once a week, working out- 3 times a week, etc.):

_____
_____
_____
_____
_____
_____
_____
_____

NAME (First, Last, MI) _____
SEX: M_____ F_____ AGE: _____ TODAY'S DATE: _____

PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS
THAT YOU ARE CURRENTLY TAKING.

PATIENT MEDICAL HISTORY

NAME: _____

DATE OF BIRTH: _____**AGE** _____ **SEX: M**___ **F**____ **RACE:** _____

MARITAL STATUS: _____ **NUMBER OF CHILDREN:** _____

RELIGION: (optional)_____

OCCUPATION: _____

HEIGHT: _____**ft.** _____**in. WEIGHT NOW:** _____**USUALWEIGHT:**_____

ALLERGIES: YES_____ **NO**_____

If yes, please specify below any allergies or adverse reactions to medications, food, chemicals, anesthetics, or vitamins/supplements.

NAME	TYPE OF REACTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS:

NAME	DOSE/AMOUNT	DURATION OF USE
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		

PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING

#	DATE	PRODUCT NAME	BRAND NAME	REASON	DOSAGE	FREQUENCY
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2						
3						
4						
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Abraham's Mark Comprehensive Wellness Center
1525 E. 53rd Street, Suite 530
Chicago, IL 60615
(773) 667-0766

Dear Friend:

Thank you for choosing our clinic. We believe in providing the best medical care for the unique you.

We are enclosing this letter in our patient information packet to remind you that when you obtain lab services at our clinic, those services are billed to your insurance by the individual lab companies, NOT by this clinic. Any questions about lab fees would be directed to the lab company or your insurance company. Insurance carriers only pay for covered items and services when certain rules are met. The fact that insurance carriers may not pay for a particular item or service does not mean that you should not receive it.

The various labs companies will submit your claim and you will be contacted when your claim is resolved. Contact the lab if you have any questions about your bill.

There are a few labs that are commonly covered by insurance and must be paid for at the time of service. You will be notified if the doctor has recommended these tests for you.

We aim to assist you to optimal health.

_____ _____

Date **Signature of Patient**