Dr. Ellie Laneville
Dr. Bryan Laneville

LANEVILLE FAMILY
CHIROPRACTIC
You've got one body, keep it healthy!

880 75th St.
Willowbrook, IL 60527
P: 630-325-5522

WELCOME! Thank you for choosing Laneville Family Chiropractic. We are very excited that you are here. The following information is needed in order to better serve you. Please complete all questions. If you need help, the receptionist will be happy to assist you. *PLEASE PRINT.*

Patient Information

Today's Date:____________ Last Name:_________________________________ First:_______________________ M. I.:______

Address:___________________________ City: _________________ State: ____ Zip: ________ Sex: ☐ M ☐ F Age:_______

Birth Date: _______/_______/_______ Ht: ____________ Wt: ___________ SS #: __________ - _______ - __________

Check One: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Number of children: ________

Occupation:______________________________________ Employer: _______________________________ Years on Job: _______

Spouse's Name: ___________________________________ Spouse's Occupation: _________________________________

Are you a Medicare patient?: ☐ Yes ☐ No Will you become a Medicare patient within this next year? ☐ Yes ☐ No

Is your condition related to an accident? ☐ Yes ☐ No Date of accident: _______/_______/_______

What type? ☐ Auto ☐ Work ☐ Other: ________________________ ***If Yes, please ask receptionist for additional accident forms.***

Are you suing anyone? ☐ Yes ☐ No If yes, who are you suing? ____

Contact Information

Home Phone:_______________ Office Phone:_______________ Cell Phone:_______________ Email: ________________________

In case of emergency, please contact: Name: ____________________ Best No. ________________ Relationship: ______________

How Did You Hear About Us?

☐ Personal Referral Name: _________________ ☐ Phone Book ☐ Radio

☐ Internet Web Address: ___________________ ☐ Newspaper Name: __________________ ☐ Other: ________________

☐ Lecture Location: _______________________ ☐ Health Fair/Screening Where:______________________________________

Current Health Condition

Please describe the primary complaint that brings you to our office:

____

____

When did this condition begin? Month: ____________________ Day: ___________ Year: ____________

Do you know what brought this condition on? (ex. fall, accident, etc.) ☐ Yes ☐ No

If yes, what do you think is the cause? ____

What makes the symptoms worse? (ex. sitting, heat, etc.)____

What relieves the symptoms? (ex. nothing, ice, etc.)____

Describe the symptoms: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throbbing ☐ Numb ☐ Other: ______________________

Is the pain localized, or does is radiate? ☐ Localized ☐ Radiate Where: ____

How often do you experience the symptoms? ☐ Constantly ☐ Frequently ☐ Off and On ☐ Occasionally ☐ Rarely

What percent of the day do you notice the pain? ☐ 0% - 25% ☐ 25% - 50% ☐ 50% - 75% ☐ 75% - 100%

What part(s) of the day do you notice the pain most? ☐ Morning ☐ Afternoon ☐ Evening ☐ All the time

Dr. Ellie Laneville
Dr. Bryan Laneville

LANEVILLE FAMILY
CHIROPRACTIC
You've got one body, keep it healthy!

880 75th St.
Willowbrook, IL 60527
P: 630-325-5522

On a scale of 0-10, 0 being no pain and 10 being the worst, please rate your pain. (circle one)

0 1 2 3 4 5 6 7 8 9 10

List any other doctors seen, the type of doctor, treatments and results obtained:

____

____

Please list other specialists and their phone number (if available):

Medical Doctor ______________________________ Phone: ______________________
Dentist ______________________________ Phone: ______________________
Chiropractor ______________________________ Phone: ______________________
Personal Trainer ______________________________ Phone: ______________________
Nutritionist ______________________________ Phone: ______________________
Physical Therapist ______________________________ Phone: ______________________
Other ______________________________ Phone: ______________________
Other ______________________________ Phone: ______________________

Secondary Complaints

List any other significant areas of complaint and when they approximately began:

1. ____Date:______________
2. ____Date:______________
3. ____Date:______________
4. ____Date:______________

Additional information you would like the doctor to know:

____

____

Past Health History

List all previous surgeries and their dates:

____

____

List any medications you are taking and what condition you are taking it for:

____

____

____

List any allergies: ____

Please check the conditions you have or have had in the past:

❐ ADD/ADHD
❐ Anemia
❐ Arthritis
❐ Appendicitis
❐ Arteriosclerosis
❐ Asthma
❐ Autism
❐ Cancer
❐ Chicken Pox
❐ Chronic fatigue
❐ Cold Sores
❐ Concussion
❐ Depression
❐ Diabetes
❐ Eczema
❐ Epilepsy
❐ Fibromyalgia
❐ Goiter
❐ Gout
❐ Heart Disease ____________
❐ Hepatitis
❐ HIV/AIDS
❐ Hypertension
❐ Hypoglycemia
❐ Hyperglycemia
❐ Influenza
❐ Measles
❐ Mental Disorder ___________
❐ Multiple sclerosis
❐ Mumps
❐ Parkinson's disease
❐ Pneumonia
❐ Polio
❐ Rheumatoid arthritis
❐ Sinusitis
❐ Stroke
❐ Tuberculosis
❐ Venereal infection
❐ Whooping Cough
❐ Other ________________
❐ Other ________________
❐ Other ________________
❐ Other ________________
❐ Other ________________

Dr. Ellie Laneville
Dr. Bryan Laneville

LANEVILLE FAMILY
CHIROPRACTIC
You've got one body, keep it healthy!

880 75th St.
Willowbrook, IL 60527
P: 630-325-5522

Musculo-Skeletal System Review

Please Check Symptoms that you have or have occurred within the past *1 year*:

Head:
- ❒ Headaches
- ❒ Migraines
- ❒ Head feels heavy
- ❒ Vertigo
- ❒ Light headed
- ❒ Dizziness
- ❒ Loss of concentration
- ❒ Loss of memory
- ❒ Loss of balance
- ❒ TMJ – Jaw pain/clicking

Neck:
- ❒ Pain in neck
- ❒ Pain with movement
- ❒ Swelling in neck
- ❒ Stiffness in neck
- ❒ Pinched nerve in neck
- ❒ Neck feels out of place
- ❒ Muscle spasms
- ❒ Grinding sounds in neck
- ❒ Popping sounds in neck
- ❒ Limited neck movement

Shoulders:
- ❒ Pain in shoulder joint
- ❒ Pain across shoulders
- ❒ Muscle spasms
- ❒ Can't raise arm
  - ❒ Above shoulder
  - ❒ Above head
- ❒ Tension in shoulders

Arms and Hands:
- ❒ Pain in upper arm
- ❒ Pain in forearm
- ❒ Pain in hands
- ❒ Pain in fingers
- ❒ Pins and needles
  - ❒ In arms
  - ❒ In fingers
- ❒ Loss of grip strength
- ❒ Cold hands
- ❒ Swollen fingers

Mid-Back:
- ❒ Mid-back pain
- ❒ Pain b/n shoulder blades
- ❒ Sharp stabbing pain
- ❒ Dull ache
- ❒ Pain from front to back
- ❒ Pain over kidney area
- ❒ Muscle spasms

Low Back:
- ❒ Lower back pain
- ❒ Lower back feels out
- ❒ Muscle spasms
- ❒ Pinched nerve
- ❒ Herniated disc
- ❒ Radiating/shooting pain

Hips, Legs and Feet:
- ❒ Pain in buttocks
- ❒ Pain in hip
- ❒ Pain down leg
- ❒ Knee pain
- ❒ Leg cramps
- ❒ Pins and needles in legs
- ❒ Numbness in legs
- ❒ Numbness in toes
- ❒ Cold feet
- ❒ Swollen ankles
- ❒ Swollen feet

Organ System Review and Social History

Please check all that apply:

Eyes, Ears, Nose, Throat:
- ❒ Blurred vision
- ❒ Double vision
- ❒ Eye fatigue
- ❒ Excessive/lack of tearing
- ❒ Light bothers eyes
- ❒ Blindness (L / R)
- ❒ Loss of hearing
- ❒ Pain in ears
- ❒ Ear infections
- ❒ Ringing in ears
- ❒ Nose bleeds
- ❒ Pressure over eyes
- ❒ Frequent colds
- ❒ Loss of smell
- ❒ Allergies
- ❒ Sinusitis
- ❒ Pain in throat
- ❒ Bleeding gums
- ❒ Difficulty swallowing
- ❒ Loss of taste

Cardiovascular:
- ❒ Swelling Where:______
- ❒ Chest pain
- ❒ Irregular heart beat
- ❒ Blue or purple skin/nails
- ❒ Heart attack When:____
- ❒ High blood pressure
- ❒ Blood vessel disease
- ❒ Fainting
- ❒ Rapid/slow heart beat

Gastrointestinal:
- ❒ Poor/excessive appetite
- ❒ Heartburn
- ❒ Nausea and vomiting
- ❒ Abdominal pain
- ❒ Irritable bowel syndrome
- ❒ Diarrhea
- ❒ Constipation
- ❒ Hemorrhoids

Respiratory:
- ❒ Shortness of breath
- ❒ Dry cough
- ❒ Productive cough
- ❒ Coughing up blood
- ❒ Wheezing

Genitourinary:
- ❒ Bladder trouble
- ❒ Painful/excessive urination
- ❒ Odiferous urination
- ❒ Discolored urine

General:
- ❒ Nervousness
- ❒ Irritability
- ❒ Fatigue
- ❒ Depression
- ❒ Panic attacks
- ❒ Problems sleeping

Men Only:
- ❒ Prostate Problems
- ❒ Impotence

Women Only:
- ❒ Painful periods
- ❒ Spotting
- ❒ Premenstrual symptoms
- ❒ Irregular periods
- ❒ Lumps/pain in breast
- ❒ Vaginal discharge
- ❒ Taking birth control pills
- ❒ # of pregnancies _________
- ❒ # of deliveries ___________

Dr. Ellie Laneville
Dr. Bryan Laneville

LANEVILLE FAMILY
CHIROPRACTIC
You've got one body, keep it healthy!

880 75th St.
Willowbrook, IL 60527
P: 630-325-5522

Social History:

Recreation is:
- ❒ sufficient
- ❒ not sufficient

Family stress is:
- ❒High
- ❒Medium
- ❒Low

Diet is:
- ❒ balanced
- ❒ not balanced

Rest is:
- ❒ sufficient
- ❒ not sufficient

My job stress is:
- ❒Severe
- ❒High
- ❒Moderate
- ❒Minimal
- ❒None

- ❒ Smoking: # pks____ yrs____
- ❒ Other tobacco use
- ❒ Alcohol use: #/wk ________
- ❒ Drink coffee or tea

Rules and Regulations Regarding Diagnostic Radiology in This Office

Please Fill-in and Sign Where Appropriate

I, ____, authorize the performance of diagnostic x-ray examination of myself, which the doctors at Laneville Family Chiropractic, P.C. may consider necessary or advisable in the course of my examination or treatment. I acknowledge that these x-rays are the sole property of Laneville Family Chiropractic, P.C. and as such will be used exclusively for diagnostic purposes unique to the care of Laneville Family Chiropractic, P.C.

Signature: ____________________________ **Date:** ______________

I, _______________________________________, authorize the performance of diagnostic x-ray examination of my child or ward, __________________________________, which the above doctors at Laneville Family Chiropractic, P.C. may consider necessary or advisable in the course of examination and treatment. I acknowledge that these X-rays are the sole property of Laneville Family Chiropractic, P.C. and as such will be used exclusively for diagnostic purposes unique to the care of Laneville Family Chiropractic, P.C. The patient is a minor of _______ years of age.

Signature: ____________________________ **Date:** ______________

VERIFICATION THAT YOU ARE NOT PREGNANT

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctors have my permission to perform diagnostic x-ray examination. I have been advised that x-rays could be hazardous to an unborn child.

Date of last menstrual period: ________________

Signature: ____________________________ **Date:** _______________

Disclosure for Use of First and Last Name

This office is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to the use of your name.

By way of signing this form, I release this office from all liability and authorize the use of my full name for the purpose of greeting me, announcing me into a room, or around the office in the presence of others. This is effective as of April 14, 2003 and remains in effect until further notice.

Patients (Printed) Name: _______________________________

Patient's Signature: __________________________________ **Date:** ______________

Authorized Facility Signature: __________________________ **Date:** ______________

Dr. Ellie Laneville
Dr. Bryan Laneville

LANEVILLE FAMILY
CHIROPRACTIC
You've got one body, keep it healthy!

880 75th St.
Willowbrook, IL 60527
P: 630-325-5522

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

This chiropractic office has one goal. ***Our ONLY practice objective is to reduce a major interference to the expression of the body's innate intelligence. Our only method is specific adjusting to correct vertebral subluxations .*** It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

The undersigned patient understands that the doctors at Laneville Family Chiropractic, P.C. have concentrated their practice to the analysis and adjustment of the Atlas Subluxation Complex Syndrome. This is a stressor to the central nervous system and displaces the patient's center of gravity from their vertical axis. This can also affect the peripheral nerves that radiate throughout your body. Spinal and body distortion then develop. Adjustments are ONLY given when the stressor at the brain stem level (top of the spinal cord) is detected. Adjustments are not necessarily given on every office visit. Since an adjustment uses very little depth, the patient feels very little, if any force.

Adjustment of the Atlas Subluxation Complex Syndrome does not address all aspects of health. I understand that the doctors strongly recommend that I obtain regular examination from my personal Medical Doctors for overall diagnosis and care of conditions and/or ailments that may not be due to or respond to the effect of the vertebra or vertebrae that should be balancing the head.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care; including the risk that care I receive in this clinic may not accomplish the desired objective. I acknowledge that no guarantees have been provided to me with regard to the results of the care I will receive. I am aware that the success of any case depends on factors beyond the control of the doctor including compliance by the patient with all instructions and directions.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or otherwise unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

It is the policy of Laneville Family Chiropractic, PC that all charges will be paid by cash, check or credit card at the time services are rendered. If there are any questions or concerns about this policy please speak to the receptionist at this time.

Medicare Patients:
Laneville Family Chiropractic is not a participant in the Medicare program. After you have met your deductible, Medicare Part B pays for a portion of the visits when you are adjusted. They will not pay for other services, e.g. x-rays or office visits when there is only a spinal examination given.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

I have read and fully understand the above statements.

Patient Signature: ______________________________________ **Date:** __________________

Guardian's Signature (For Minors): ____________________________ **Date:** ____________