

# ELITE HEALTH & WELLNESS CENTERS

60 W Illinois Ave Palatine, IL. 60067

## Chiropractic Medicine Division

### General Information

(if more space is needed when filling in info, feel free to provide your own separate sheet.)

Name: First \_\_\_\_\_ M \_\_\_\_\_ Last \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender:  Male  Female Marital Status:  Married  Single  Divorced  Widowed

Primary Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home#( ) \_\_\_\_\_ Work# \_\_\_\_\_

Cell # ( ) \_\_\_\_\_ Preferred Method of contact (circle one): Home Work Cell Text Email

Email: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

Highest Education Level:  High School  Graduate  Post-Graduate

Job Title: \_\_\_\_\_ Nature of Business: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### Insurance Information

*If we are in network and you would like us to submit your claim directly to your insurance company, please fill out info below. We will need a copy of your current insurance card. Please carefully read the additional insurance forms you will need to fill out separately from this intake.*

### Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with: *Name of Insurance Company(ies)* \_\_\_\_\_

\_\_\_\_\_ and assign directly to Dr. Leahy all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents. For the purpose of obtaining payment for services and determining insurance for the purpose of benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian, or Personal Representative \_\_\_\_\_

Date \_\_\_j\_\_\_j\_\_\_ Relationship to Patient \_\_\_\_\_

### Payment information

*Payment is due at time of service, no exceptions. If you would like to submit a claim for payment of services to your insurance company, we will provide you with a statement for a small setup and statement fee. Please see our insurance policy handouts for more information. Knowledge and awareness of insurance coverage is the sole responsibility of the patient.*

# Elite Health&Wellness Centers

60 W Illinois Ave Palatine, IL 60067 - 847-221-2225

## Health Concerns & Goals

Please list current and/or ongoing areas of concern you would like to address in order of priority.

What do you hope to achieve with your visits here? \_\_\_\_\_

\_\_\_\_\_

When was the last time you felt exceptionally well? \_\_\_\_\_

**Health Concern or Goal** (Please describe as many details as you can) \_\_\_\_\_

When did you first notice symptoms appear? \_\_\_\_\_ Was there a trigger? \_\_\_\_\_

Is this condition getting:  Better  Worse  About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

If pain is associated with your condition, please check all that apply: *Type of pain*

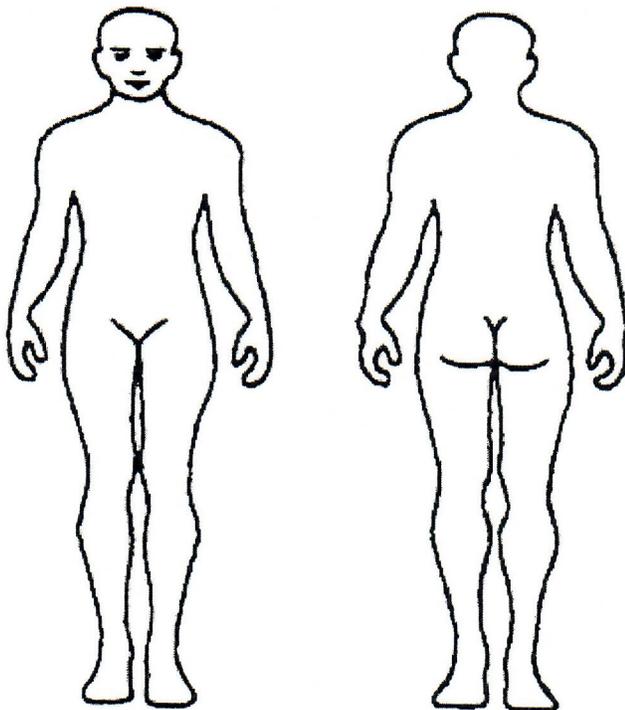
- Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning  
 Tingling  Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you experience this condition? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Anything else you feel is important about this condition? \_\_\_\_\_

PLEASE MARK ANY AREAS OF CONCERN



**Medical History** *continued*

**Current Medications** *(Both prescription and over-the-counter)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

**Nutritional Supplements:** *(Vitamins, Minerals, Herbs, & Homeopathy)* *If more space is needed, please write on separate sheet.*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

**Hospitalizations**  None

Date \_\_\_\_\_ - Reason \_\_\_\_\_  
 \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_ - \_\_\_\_\_

**Allergies**

Medication/Supplement/Food	Reaction

**Medical History**

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

Doctor of Chiropractic Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

M.D. / D.O. Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

Physical Therapist Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

Other: Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

# Elite Health&Wellness Centers

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## Diseases/Diagnosis/Conditions: continued

### Inflammatory/Autoimmune

- Chronic Fatigue Syndrome \_\_\_/\_\_\_
- Autoimmune Disease \_\_\_/\_\_\_
- Rheumatoid Arthritis \_\_\_/\_\_\_
- Lupus SLE \_\_\_/\_\_\_
- Immune Deficiency Disease \_\_\_/\_\_\_
- Herpes-Genital \_\_\_/\_\_\_
- Cold Sores \_\_\_/\_\_\_
- Severe Infectious Disease \_\_\_/\_\_\_
- Poor Immune Function (*frequent infections*) \_\_\_/\_\_\_
- Food Allergies \_\_\_/\_\_\_
- Environmental Allergies \_\_\_/\_\_\_
- Multiple Chemical Sensitivities \_\_\_/\_\_\_
- Latex Allergy \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

### Respiratory Diseases

- Asthma \_\_\_/\_\_\_
- Chronic Sinusitis \_\_\_/\_\_\_
- Bronchitis \_\_\_/\_\_\_
- Emphysema \_\_\_/\_\_\_
- Pneumonia \_\_\_/\_\_\_
- Tuberculosis \_\_\_/\_\_\_
- Sleep Apnea \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

### Head, Eyes, & Ears

- Conjunctivitis \_\_\_/\_\_\_
- Distorted Sense of Smell \_\_\_/\_\_\_
- Distorted Taste \_\_\_/\_\_\_
- Ear Fullness \_\_\_/\_\_\_
- Ear Pain \_\_\_/\_\_\_
- Hearing Loss \_\_\_/\_\_\_
- Hearing Problems \_\_\_/\_\_\_
- Headache \_\_\_/\_\_\_
- Migraine \_\_\_/\_\_\_
- Sensitivity to Loud Noises \_\_\_/\_\_\_
- Vision Problems (*other than glasses*) \_\_\_/\_\_\_
- Macular Degeneration \_\_\_/\_\_\_
- Vitreous Detachment \_\_\_/\_\_\_
- Retinal Detachment \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

### Nails

- Bitten \_\_\_/\_\_\_
- Brittle \_\_\_/\_\_\_
- Curve Up \_\_\_/\_\_\_
- Frayed \_\_\_/\_\_\_
- Fungus-Fingers \_\_\_/\_\_\_
- Fungus-Toes \_\_\_/\_\_\_
- Pitting \_\_\_/\_\_\_
- Ragged Cuticles \_\_\_/\_\_\_
- Ridges \_\_\_/\_\_\_
- Soft \_\_\_/\_\_\_
- Thickening of Finger Nails \_\_\_/\_\_\_
- Thickening of Toenails \_\_\_/\_\_\_
- White Spots/Lines \_\_\_/\_\_\_

### Skin Diseases

- Acne on Back \_\_\_/\_\_\_
- Acne on Chest \_\_\_/\_\_\_
- Acne on Face \_\_\_/\_\_\_
- Acne on Shoulders \_\_\_/\_\_\_
- Athlete's Foot \_\_\_/\_\_\_
- Bumps on Back of Upper Arms \_\_\_/\_\_\_
- Cellulite \_\_\_/\_\_\_
- Dark Circles Under Eyes \_\_\_/\_\_\_
- Ears Get Red \_\_\_/\_\_\_
- Easy Bruising \_\_\_/\_\_\_
- Lack of Sweating \_\_\_/\_\_\_
- Hives \_\_\_/\_\_\_
- Jock Itch \_\_\_/\_\_\_
- Lackluster Skin \_\_\_/\_\_\_
- Moles w/ Color/Size Change \_\_\_/\_\_\_
- Oily Skin \_\_\_/\_\_\_
- Pale Skin \_\_\_/\_\_\_
- Patchy Dullness \_\_\_/\_\_\_
- Rash \_\_\_/\_\_\_
- Red Face \_\_\_/\_\_\_
- Sensitive to Bites \_\_\_/\_\_\_
- Sensitive to Poison Ivy/Oak \_\_\_/\_\_\_
- Shingles \_\_\_/\_\_\_
- Skin Darkening \_\_\_/\_\_\_
- Strong Body Odor \_\_\_/\_\_\_
- Hair Loss \_\_\_/\_\_\_
- Vitiligo \_\_\_/\_\_\_
- Eczema \_\_\_/\_\_\_
- Psoriasis \_\_\_/\_\_\_
- Melanoma \_\_\_/\_\_\_
- Skin Cancer \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

### Neurologic/Mood

- Depression \_\_\_/\_\_\_
- Anxiety \_\_\_/\_\_\_
- Bipolar Disorder \_\_\_/\_\_\_
- Schizophrenia \_\_\_/\_\_\_
- Headaches \_\_\_/\_\_\_
- Migraines \_\_\_/\_\_\_
- ADD/ADHD \_\_\_/\_\_\_
- Autism \_\_\_/\_\_\_
- Mild Cognitive Impairment \_\_\_/\_\_\_
- Memory Problems \_\_\_/\_\_\_
- Parkinson's Disease \_\_\_/\_\_\_
- Multiple Sclerosis \_\_\_/\_\_\_
- ALS \_\_\_/\_\_\_
- Seizures \_\_\_/\_\_\_
- Other Neurological Problems \_\_\_\_\_

### Blood Type

- A     B     AB     O     Rh+     unknown

### Injuries

*Check box if yes and provide date/description*

- Back Injury \_\_\_/\_\_\_ \_\_\_\_\_
- Head Injury \_\_\_/\_\_\_ \_\_\_\_\_
- Neck Injury \_\_\_/\_\_\_ \_\_\_\_\_
- Broken Bones \_\_\_/\_\_\_ \_\_\_\_\_

**Diseases/Diagnosis/Conditions: continued**

Female Reproductive

- Breast Cysts \_\_\_/\_\_\_
- Breast Lumps \_\_\_/\_\_\_
- Breast Tenderness \_\_\_/\_\_\_
- Ovarian Cysts \_\_\_/\_\_\_
- Poor Libido \_\_\_/\_\_\_
- Vaginal Discharge \_\_\_/\_\_\_
- Vaginal Odor \_\_\_/\_\_\_
- Vaginal Itch \_\_\_/\_\_\_
- Vaginal Pain with Sex \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Surgeries

Check box if yes and provide date of surgery

- Appendectomy \_\_\_/\_\_\_
- Hysterectomy +/- Ovaries \_\_\_/\_\_\_
- Gall Bladder \_\_\_/\_\_\_
- Hernia \_\_\_/\_\_\_
- Tonsillectomy \_\_\_/\_\_\_
- Dental Surgery \_\_\_/\_\_\_
- Joint Replacement: Knee/Hip \_\_\_/\_\_\_
- Heart Surgery: Bypass Valve \_\_\_/\_\_\_
- Angioplasty or Stent \_\_\_/\_\_\_
- Pacemaker \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_
- None

Male Reproductive

- Discharge from penis \_\_\_/\_\_\_
- Ejaculation Problem \_\_\_/\_\_\_
- Genital Pain \_\_\_/\_\_\_
- Impotence \_\_\_/\_\_\_
- Prostate or Urinary Infection \_\_\_/\_\_\_
- Lumps in Testicles \_\_\_/\_\_\_
- Poor Libido (Sex Drive) \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Preventive Tests

Check box if yes and provide date of most recent test

- Blood Tests \_\_\_/\_\_\_
- Full Physical Exam \_\_\_/\_\_\_
- X-Ray \_\_\_/\_\_\_ Body Part? \_\_\_\_\_
- Dental X-Ray \_\_\_/\_\_\_
- Bone Density \_\_\_/\_\_\_
- Colonoscopy \_\_\_/\_\_\_
- Cardiac Stress Test \_\_\_/\_\_\_
- EKG \_\_\_/\_\_\_
- Hemocult Test (stool test for blood) \_\_\_/\_\_\_
- MRI \_\_\_/\_\_\_
- CT Scan \_\_\_/\_\_\_
- Upper Endoscopy \_\_\_/\_\_\_
- Upper GI Series \_\_\_/\_\_\_
- Ultrasound \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

**Diseases/Diagnosis/Conditions: Check appropriate box and provide Month/Year of onset  Past Condition  Ongoing Condition**

Gastrointestinal

- Irritable Bowel Syndrome \_\_\_/\_\_\_
- Inflammatory Bowel Disease \_\_\_/\_\_\_
- Crohn's \_\_\_/\_\_\_
- Ulcerative Colitis \_\_\_/\_\_\_
- Gastritis or Peptic Ulcer Disease \_\_\_/\_\_\_
- GERD (reflux) \_\_\_/\_\_\_
- Celiac Disease \_\_\_/\_\_\_
- Hemorrhoids \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Cardiovascular

- Heart Attack \_\_\_/\_\_\_
- Other Heart Disease \_\_\_/\_\_\_
- Stroke \_\_\_/\_\_\_
- Elevated Cholesterol \_\_\_/\_\_\_
- Arrhythmia (irregular heart rate) \_\_\_/\_\_\_
- Hypertension (high blood pressure) \_\_\_/\_\_\_
- Rheumatic Fever \_\_\_/\_\_\_
- Mitral Valve Fever \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Cancer

- Lung Cancer \_\_\_/\_\_\_
- Breast Cancer \_\_\_/\_\_\_
- Colon Cancer \_\_\_/\_\_\_
- Ovarian Cancer \_\_\_/\_\_\_
- Prostate Cancer \_\_\_/\_\_\_
- Skin Cancer \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Genital & Urinary Systems

- Kidney Stones \_\_\_/\_\_\_
- Gout \_\_\_/\_\_\_
- Interstitial Cystitis \_\_\_/\_\_\_
- Frequent Urinary Tract Infections \_\_\_/\_\_\_
- Frequent Yeast Infections \_\_\_/\_\_\_
- Erectile or Sexual Dysfunctions \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Metabolic/Endocrine

- Type 1 Diabetes \_\_\_/\_\_\_
- Type 2 Diabetes \_\_\_/\_\_\_
- Hypoglycemia \_\_\_/\_\_\_
- Metabolic Syndrome (Insulin Resistance/ Pre-Diabetes) \_\_\_/\_\_\_
- Hypothyroidism (low thyroid) \_\_\_/\_\_\_
- Hyperthyroidism (overactive thyroid) \_\_\_/\_\_\_
- Endocrine Problems \_\_\_/\_\_\_
- Polycystic Ovarian Syndrome (PCOS) \_\_\_/\_\_\_
- Infertility \_\_\_/\_\_\_
- Weight Gain \_\_\_/\_\_\_
- Weight Loss \_\_\_/\_\_\_
- Frequent Weight Fluctuations \_\_\_/\_\_\_
- Bulimia \_\_\_/\_\_\_
- Anorexia \_\_\_/\_\_\_
- Binge Eating Disorder \_\_\_/\_\_\_
- Night Eating Syndrome \_\_\_/\_\_\_
- Eating Disorder (non-specific) \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Musculoskeletal/Pain

- Osteoarthritis \_\_\_/\_\_\_
- Fibromyalgia \_\_\_/\_\_\_
- Chronic Pain \_\_\_/\_\_\_
- Tendonitis \_\_\_/\_\_\_
- Tension Headaches \_\_\_/\_\_\_
- TMJ Problems \_\_\_/\_\_\_
- Foot Cramps \_\_\_/\_\_\_
- Joint Deformity \_\_\_/\_\_\_
- Joint Pain \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

# Elite Health&Wellness Centers

60 W Illinois Ave. Palatine, IL 60067 - 847-221-2225

## Family History

<i>Check family members that apply</i>	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis <i>(Rheumatoid, Psoriatic, Ankylosing Spondylitis)</i>												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases <i>(such as Lupus)</i>												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities, or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse <i>(such as Alcoholism)</i>												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar / Mood Disorder												
Other:												

# Elite Health&Wellness Centers

60 W Illinois Ave. Palatine, IL 60067 - 847-221-2225

## HIPAA AUTHORIZATIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of (*PHI*) be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

<input type="checkbox"/> Home Telephone _____	<input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to leave message with detailed information	<input type="checkbox"/> O.K. to mail to my home
<input type="checkbox"/> Leave message with call back number only	<input type="checkbox"/> O.K. to mail to my office
	<input type="checkbox"/> O.K. to fax to this number _____
<input type="checkbox"/> Cell Telephone _____	<input type="checkbox"/> _____
<input type="checkbox"/> O.K. to leave message with detailed information	<input type="checkbox"/> Other _____
<input type="checkbox"/> Leave message with call back number only	EMAIL: _____
<input type="checkbox"/> O.K. to send Text Messages regarding my appointments	

Work Telephone

O.K. to leave message with detailed information

Leave message with call back number only

I acknowledge that I have received a copy/have read the notice of Privacy Practices of Elite Health and Wellness Center/Illinois Chiropractic Centers

_____	_____
Print Patient Name	Date of Birth
_____	_____
Patient Signature	Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency**

AUTHORIZED PERSON(S) TO RECEIVE HEALTHCARE INFORMATION

# Elite Health&Wellness Centers

60 W Illinois Ave. Palatine, Il. 60067 - 847-221-2225

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

---

Name of Patient

Date

# Elite Health & Wellness Centers

60 W Illinois Ave, Palatine, Illinois 60067  
Phone: 847-221-2225 • [drlehwc@gmail.com](mailto:drlehwc@gmail.com)

If you are using your insurance benefits, Elite Health & Wellness Centers, requires the patient portion of the first session be paid by credit – Visa or Master Card. This is due to the high incidence of unreported deductibles and the fact that insurance may not cover certain services. By paying via credit card, you acknowledge that this credit card information will be automatically kept on file via PCI-compliant encrypted code with the following credit card processor: International Bancard. Health Savings Account cards may also be kept on file as the primary form of payment but must still have a back-up credit card on file in case HSA funds are depleted. You further agree and understand that if insurance does not pay the contracted rate for services, any remaining balance due that is the legal patient responsibility will be charged to this Health Savings Card or Credit Card on file. This amount typically includes co-pays, co-insurance, and deductibles that have not yet been met or were quoted incorrectly by the insurance company.

If you are not using Insurance Benefits your charges for the services are due at the time of service and will be charged to the card on file.

By signing my name below, I authorize Elite Heath & Wellness Centers to keep my credit card on file. I have the right to request my credit card to be removed via written or verbal request.

THIS AUTHORIZATION EXPIRES 1 YEAR FROM THE DATE OF OUR FINAL SESSION

Patient Legal Name - \_\_\_\_\_  
Last First

Card Holder Name \_\_\_\_\_

Card Number \_\_\_\_\_

Exp Date \_\_\_\_\_ Security Code \_\_\_\_\_

Signature \_\_\_\_\_