Peak Performance Intake Form

Name_____ Cell Phone _____

Address _____ Work Phone _____

City, State, Zip_____ Birthdate _____

Male/Female Age_____ SS# _____ E-mail _____

Occupation_____ Employer_____ Marital Status: M S

Please answer the following questions accurately so we can do our best to help you reach your goals.

1. Most of our patients are referred to our office by a caring family member or friend. What made you decide to visit our office?

   Friend/ Family/ Workshop/ Other: _____

2. What is your purpose for coming to see us today?_____

   _____

   _____

3. Please check-off and list any health symptoms or health complaints you are experiencing:

___Neck pain L / R	___Arm pain/Numbness L / R	___Stress/ Irritability	___Overweight
___Knee pain L / R	___Leg pain/Numbness L / R	___Fatigue	___Allergies
___Mid-back pain L / R	___Tingling in Arms or Legs L / R	___Constipation	___Stress-Irritability-mood problems
___Low-back pain L / R	___Headaches/ Migraines	___Digestive problems	___Menstrual pain
___Shoulder pain L / R	___Fibromyalgia	___Sleeping problems	___Skin problems

Other: _____

	List the conditions concern you the most? ⬇	How long have you had it? ⬇	How often do you have it? ⬇	How intense? 1 to 10 ("10" = the worst)
A.	_____	_____	_____	_____
	How does it feel ?_____			
B.	_____	_____	_____	_____
	How does it feel ?_____			
C.	_____	_____	_____	_____
	How does it feel ?_____			
D.	_____	_____	_____	_____
	How does it feel ?_____			

Check off what have you tried to help these problems & circle the results:

☐ Medications- helped...	much	little	no help	made worse	☐ Exercise- helped...	much	little	no help	made worse
☐ Physical Therapy- helped...	much	Little	no help	made worse	☐ Nutrition- helped...	much	little	no help	made worse
☐ Diet- helped...	much	Little	no help	made worse	☐ Chiropractic- helped...	much	little	no help	made worse
☐ Cleanse / Detox- helped...	much	Little	no help	made worse	☐ Stretching- helped...	much	little	no help	made worse

_____

_____

Peak Performance Intake Form

Accident History:

1. The vast majority of our patients have experienced literally dozens of impacts that could cause problems with the spine and other parts of the body, which may be causing the very symptoms they are experiencing. Please answer the following:

   A. When was your most recent car accident?

   _____ ( ) no treatment ( ) just a check up ( ) treatment done

   A. When was your car accident before that?

   _____ ( ) no treatment ( ) just a check up ( ) treatment done

   A. When was your car accident before that?

   _____ ( ) no treatment ( ) just a check up ( ) treatment done

2. Most people have had a slip, strain, twist, or fall at work, whether it was reported or not. When was you most recent stress or strain at work?

   _____Was any treatment received? ( ) no treatment ( ) just a check up ( ) treatment

3. When was your most recent stress or strain while doing sports, exercise or recreational actives? What happened?

_____

_____

4. What accidents occurred at home or elsewhere we haven't mentioned yet? (slips, falls, hitting head, knocked out, etc)

_____

_____

_____

Please check all that apply to you:

( ) Overweight	( ) Vestibular (balance) disorders	( ) Anxiety
( ) Diabetes	( ) Fibromyalgia	( ) Depression
( ) Hypertension or Heart disease	( ) More than 2 episodes in past	( ) Other mental disorder
	( ) Joint replacement	( ) Chronic fatigue

What other health conditions do you have you have not listed yet?:_____

_____

I consent to receiving a health screening. I realize that I am not receiving a diagnosis or treatment for any conditions that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and or clinic.

Our Consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Please check all that apply to you:

( ) Yes, I am pregnant. ( ) No, I am definitely not pregnant. ( ) There is a possibility that I may be pregnant at this time.

( ) I request that X-ray films not be taken because:_____

Signature: _____ Date: _____

Peak Performance Healthcare
1749 N Wells Chicago, IL 60614

PATIENT'S RELEASE OF THE PROVIDER OF SERVICE AND THE CLINIC

The undersigned hereby represents that I have disclosed all my pertinent information regarding my health profile to the provider of service during my examination. Patient further represents and guarantees that I have disclosed all medications that I am currently consuming to this provider of service during my examination and from whom, if any, I am obtaining my medications.

I understand that this provider of services makes a determination based on full disclosure from the patient.

I acknowledge that this provider of services reserves the right to limit any patient's medications to an appropriate amount based on the disclosed information from the patient during the examination.

Should information be obtained that in any way suggest false representation were made to this provider of service by the patient, I, without reservation, waive any and all rights to any claim, of any type or nature whatsoever including but not limited to monetary damages, which I have now or in the future may accrue against the provider of service and this clinic.

As a patient I also understand that if I go to another provider of service during the time frame of treatment at this clinic, I am to notify this clinic and its representatives immediately of any other medications I might be receiving, and that said notification must be made in writing by and between this clinic and or its representative and myself. As the patient, I will also receive a copy of this notification after it is awarded.

As the patient, I have read and understand this release. I also understand that this release constitutes a legal and binding document.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Peak Performance Healthcare
1749 N Wells Chicago, IL 60614

HIPAA AND PRIVACY PRACTICES FORM

Introduction

At Peak Performance Healthcare, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31th, 2003 and applies to all protected health information as defined by federal regulation.

Uses and Disclosures

1. We use your health information to document and plan treatment, progress, planning, etc.
2. We use your health information for payment.
3. We use your health information for regular health operations
4. There are services provided in our organization through contacts with business associates. Examples include outside labs, x-ray, transcription services.
5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which Peak Performance is permitted or required to disclose confidential information without the individual's written authorization.

1. Uses and disclosures for public health activities;
2. Reporting victims of abuse, neglect, or domestic violence;
3. Disclosures for judicial and administrative proceedings;
4. Disclosures for law enforcement purposes;
5. Uses and disclosures for cadaveric organ, eye or tissue donation purposes;
6. Disclosures to avert a serious threat to health or safety; and
7. Uses and disclosures for specialized government functions.

Separate Statements for Certain Uses or Disclosures Alta Health Services, Inc may contact patients with appointment reminders, requests for the patient to contact Peak Performance Healthcare for appointments, notices and letters concerning medical findings Peak Performance Healthcare may also contact the patient about treatments alternatives or other health related benefits and services that may be of interest to the individual. Effective Date of this notice is April 1, 2003; Updated April 10, 2008.

Individual Rights

Although your health record is the physical property of Peak Performance Healthcare the information belongs to you. You have the right to:

1. The right to request restrictions on certain uses and disclosures of your information;
2. The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
3. The right to receive confidential communications;
4. The right to obtain a copy or inspect your health information;
5. The right to amend protected health information;
6. The right to receive an accounting of disclosures of protected health information.

Peak Performance Healthcare **Rights**

1. Peak Performance Healthcare has 30 days with which to comply with a patient's request to review or copy their health information. Peak Performance Healthcare is allowed an additional 30 days if the record is off site Peak Performance Healthcare may charge a fee for copying the health record.
2. The physicians have the right to review the record and remove any information that they deem to be harmful to either the patient or to another individual;
3. The patient will be supervised by Medical Center staff during any review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record. Peak Performance Healthcare will charge staff time for this service.

Peak Performance Healthcare **Duties**

1. Peak Performance Healthcare is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. Peak Performance Healthcare is required to abide by the terms of this Notice; and
3. Peak Performance Healthcare reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted in the patient waiting area.

Complaints

Individuals may complain to the Office Manager in writing to address above. You may also contact the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., S.W.,Rm. 509F, HHH Building, Washington DC 20201.
Further Information-Please contact the SMC administrator at 747-5861 for further information. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____