DUPAGE CHIROPRACTIC CENTRE, LTD.
DR. SALLY A. PEPPING
DR. DON MERTES

If your injuries were the result of a car accident or work injury, please notify the front desk for additional paperwork or download the additional paperwork from our website www.dupagechirorpactic.com.

We would like to thank you for choosing our office. We know that when it comes to health care that finding the right fit is a personal choice. We want you to know that we will do our very best to exceed your expectations.

It is important that you are able to fill out the following forms as truthfully and accurately as possible. Your answers, even if they do not seem relevant to your complaints, are the pathway to finding out what is happening with your health and what will be the best treatment program for you.

If you need any help with your paperwork, please ask one of our staff to help you.
It is our privilege to assist you.

We look forward to helping you,

Dr. Sally A. Pepping, D.C.
Dr. Don Mertes, D.C
And Staff

DuPage Chiropractic Centre, Ltd

Financial Policy

Our services at DuPage Chiropractic are covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE: We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. We offer payment plans to make care affordable and obtainable.

GROUP OR INDIVIDUAL INSURANCE: It's our pleasure to have our billing department call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Your benefits will be discussed with you at your report of findings (second visit), and payment arrangements will be explained to you for any non covered services, deductibles, co-pays, or co-insurance.

"ON THE JOB" INJURY (Worker's Compensation): If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS: Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

MEDICARE: We do accept assignment from Medicare. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE: Please inform us of any secondary insurance you may have.

HEALTH SAVINGS ACCOUNT (HSA) OR FEDERAL SAVINGS ACCOUNT (FSA): Please inform us if you have one of these accounts.

DuPage Chiropractic Centre, Ltd

Intake Form - part 1

(Please Print Clearly)

Patient Name: _____ Male ❍ Female ❍
First Middle Initial Last

Home Address: _____ City:_____ State:_____ Zip: _____- _____

Please provide us with at least two ways of contacting you:

Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Marital Status: Married ❍ Single ❍ Divorced ❍ Widowed ❍

Date Of Birth: _____ Age: _____ If a minor, parent's names:_____

Email Address:_____@ _____

Social Security #: _____-_____-_____ ***This information is necessary and kept confidential***

Do you have a FSA or HSA medical spending account? No ❍ Yes ❍ *If yes, notify the front desk.*

INSURED'S EMPLOYER_____ PHONE:_____

If you have provided the front desk staff with your insurance information then you do not have to fill in the information below. However if you are not the insured, please provide us with insured's name and date of birth only:

Primary Insurance:

Insured's Name:	Date of Birth: _____/_____/_____
Relationship to Patient:	Phone:
Address:	ID #:
City/State/Zip:	Group #:

Secondary Insurance:

Insured's Name:	Date of Birth: _____/_____/_____
Relationship to Patient:	Phone:
Address:	ID #:
City/State/Zip:	Group #:

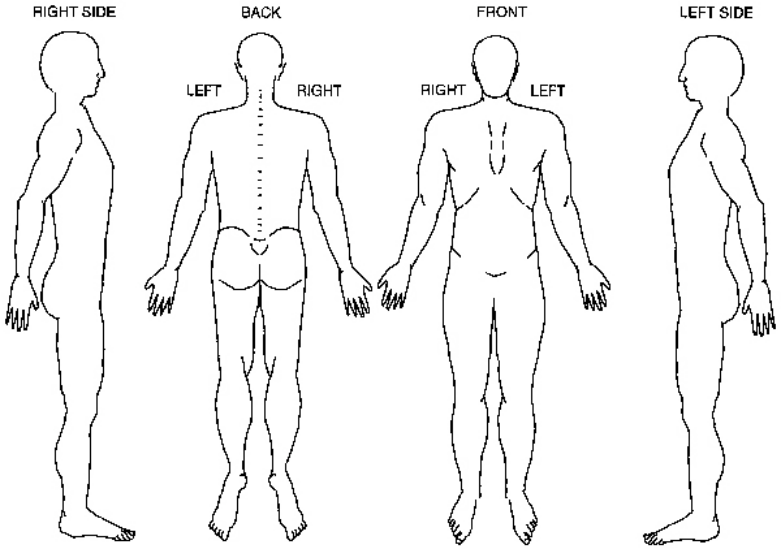
Assignment of Benefits/Release of Information:
I authorize payment of insurance benefits directly to DuPage Chiropractic Centre. I authorize the doctor to release any information to any parties necessary to secure the payment of benefits and request medical information from any source necessary in order to provide the proper quality of care and to secure payment for services. I agree to be financially responsible for all charges incurred at DuPage Chiropractic Centre including my insurance deductible, co-payment, and services not covered by my insurance company or paid in full through any settlement or court case. Any remaining balance I will pay in full per the policies of DuPage Chiropractic Centre. I consent to receive treatment by DuPage Chiropractic Centre. I have also read and understand the privacy policies of DuPage Chiropractic Centre and my privacy rights under those policies. I agree that all information provided is true to the best of my knowledge.

Patient's signature: _____ Date: _____

DuPage Chiropractic Centre, Ltd

Intake Form - part 2

Name:_____ **Date:**_____/_____/_____



Please Mark Where You Are Experiencing Symptoms:

	Comes/Goes	Constant
Low back pain	❍	❍
Mid back pain	❍	❍
Neck pain	❍	❍
Shoulder pain	❍	❍
Headaches	❍	❍
Hip pain	❍	❍
Arthritis	❍	❍
Knee pain	❍	❍
Foot pain	❍	❍
Heel pain	❍	❍

Have you **ever** had numbness/tingling?
❍ No ❍Yes Where?_____
Do you have a pace maker? ❍ No ❍Yes

When did this complaint begin? _____ **Is your complaint getting:** ❍better ❍same ❍worse

Did this injury occur: ❍ at work ❍ auto accident ❍ other

Please explain how this injury happened: _____

Have you been to a chiropractor before? ❍Yes ❍ No **When?** _____

Type of pain:

❍Sharp ❍Dull ❍Throbbing ❍ Numbness ❍ Tingling ❍Aching ❍ Shooting ❍Burning ❍Stiff ❍ Other

Aggravated by:

❍Sitting ❍Standing ❍Walking ❍ Bending ❍Sleeping ❍Sneezing/Coughing ❍Bowel Movement ❍Other

What makes it: Better? _____ Worse? _____

What have you done for it? (*Hot packs, ice, stretching, etc)* _____

Are you taking medications for this problem? _____

Treatment/tests done by other Dr.'s? *(Please name them)* _____

What is your occupation? _____

Children? ❍Yes ❍No

Name_____ Age____
Name_____ Age____
Name_____ Age____
Name_____ Age____

What would you like to accomplish through chiropractic care? _____

_____
_____
_____
_____

Other complaints? _____

How were you referred you to our clinic? ❍ Friend ❍Family _____

❍ Health Pass ❍ Newspaper ❍ Mailing ❍ Sign ❍ Ins Provider Listing ❍ Other: _____

❍ Internet ❍ Our Web Site ❍ Spinal Care Class ❍ Health screening/which one? _____

DuPage Chiropractic Centre, Ltd

Intake Form - part 3

Name: _____ Date: _____

Current History

Current Medications: _____

_____

_____

_____

Do you take blood thinners? ❍ No ❍ Yes If yes, type: _____

Vitamins, Herbs, Minerals: _____

_____

_____

_____

Allergies: _____

Social History

Habits	None	Light	Mod.	Heavy
Alcohol				
Coffee				
Smoke				
Drugs				
Exercise				

Habits	None	Light	Mod.	Heavy
Sleep				
Soda				
Salt				
Sugar				
Water				

Past History

Have you...	Y	N	If yes, explain briefly:
had hospitalizations or surgeries in the past 5 years?			
had any broken bones?			
ever had any sprains or strains?			
ever used orthotics?			
When was your last physical?			

Family History

Y	which relatives?		Y	which relatives?	
	high blood pressure			arthritis	
	high cholesterol			cancer	
	scoliosis			stroke	
	diabetes			thyroid disease	

DuPage Chiropractic Centre, Ltd

Intake Form - part 4

Name: _____ Date: _____

If you have one or more of these symptoms, there's a 95% probability you'll benefit from a Bloodprint™ food sensitivity test.

Please place a checkmark at each of your symptoms and return the completed checklist to your physician. Be sure to include symptoms that you've learned to live with.

Digestive Tract
- ❍ Belching
- ❍ Bloated Feeling
- ❍ Constipation
- ❍ Diarrhea
- ❍ Nausea
- ❍ Passing Gas
- ❍ Stomach Pains
- ❍ Vomiting

Ears
- ❍ Drainage from ear
- ❍ Ear aches
- ❍ Ear infections
- ❍ Hearing loss
- ❍ Itchy ears
- ❍ Ringing in ears

Emotions
- ❍ Aggressiveness
- ❍ Anxiety/fear
- ❍ Depression
- ❍ Irritability/anger
- ❍ Mood swings
- ❍ Nervousness

Energy & Activity
- ❍ Apathy
- ❍ Fatigue
- ❍ Hyperactivity
- ❍ Lethargy
- ❍ Restlessness
- ❍ Sluggishness

Eyes
- ❍ Blurred vision
- ❍ Dark circles
- ❍ Itchy eyes
- ❍ Sticky eyelids
- ❍ Swollen eyelids
- ❍ Watery eyes

Head
- ❍ Dizziness
- ❍ Faintness
- ❍ Headaches
- ❍ Insomnia
- ❍ Lightheadedness

Joint & Muscles
- ❍ Aches in muscles
- ❍ Arthritis
- ❍ Feeling of weakness
- ❍ Limited movement
- ❍ Pain in joints
- ❍ Passing Gas

Lungs
- ❍ Asthma/Bronchitis
- ❍ Chest congestion
- ❍ Difficulty breathing
- ❍ Shortness of breath
- ❍ Wheezing

Mind
- ❍ Confusion
- ❍ Learning disabilities
- ❍ Poor concentration
- ❍ Poor memory
- ❍ Stuttering/stammering

Mouth & Throat
- ❍ Canker sores
- ❍ Chronic coughing
- ❍ Gagging
- ❍ Often clear throat
- ❍ Sore throat
- ❍ Swollen tongue/lips/gums

Nose
- ❍ Excessive mucous
- ❍ Hay fever
- ❍ Sinus problems
- ❍ Sneezing attacks
- ❍ Stuffy nose

Skin
- ❍ Acne
- ❍ Dermatitis
- ❍ Eczema
- ❍ Excessive sweating
- ❍ Flushing/hot flashes
- ❍ Hair loss
- ❍ Hives/rashes
- ❍ Itching

Weight
- ❍ Binge eating
- ❍ Compulsive eating
- ❍ Cravings
- ❍ Excessive weight
- ❍ Underweight
- ❍ Water retention

Other
- ❍ Anaphylactic reactions
- ❍ Chest pains
- ❍ Frequent illness
- ❍ Genital itch
- ❍ Irregular heartbeat
- ❍ Rapid heartbeat
- ❍ Urgent urination

Patient's Name: _____ Phone #: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Office Use: Dx _____

DuPage Chiropractic Centre, Ltd

Office Use Only

Immuno Bloodprint IgG ELISA Food Sensitivity Assay

Immuno Bloodprint 154 (Comprehensive) ❑

Immuno Bloodprint 115 (Standard) ❑

Immuno Bloodprint 88 (Basic) ❑

Immuno Bloodprint 108 (Kosher) ❑

Immuno Bloodprint 104 (Vegetarian) ❑

4 - Day Rotation Food Plan ❑

2 - Day Rotation Food Plan ❑

Food Combining ❑

IgE36 Allergen Airborne & Food Allergy Assays

TEST ALERT: If you select more than one test in this section one or more allergens could be duplicated between panels.

Between Food/Mold ❑

Pediatric Food/Mold ❑

Additional Food/Mold ❑

Environmental ❑

Pediatric - Environmental ❑

Northeastern Inhalant ❑

Southeastern Inhalant ❑

Northwestern Inhalant ❑

Southwestern Inhalant ❑

Western Inhalant ❑

Eastern Combo ❑

Southern Combo ❑

Western Combo ❑

Additional Assays

Anti-gliadin Antibody ❑

Helicobacter Pylori (H. pylori) ❑

Sub-Fractions (Egg-2) ❑

Total IgE ❑

Candida albicans ❑

Sub-Fractions (Milk-5) ❑

Tissue Transglutaminase Antibody (tTG) ❑

Reflex Assays

Anti-gliadin Antibody ❑

Sub-Fractions (Milk 5) ❑

Sub-Fractions (Egg-2) ❑

Tissue Transglutaminase Antibody (tTG) ❑

IgE 36 - Standard Food/Mold ❑

IgE 36 - Pediatric Food/Mold ❑

IgE 36 - Additional Food ❑

IgE 36 - Environmental ❑

IgE 36 - Pediatric - Environmental ❑

IgE 36 - Northeastern Inhalant ❑

IgE 36 - Southeastern Inhalant ❑

IgE 36 - Northwestern Inhalant ❑

IgE 36 - Southwestern Inhalant ❑

IgE 36 - Western Inhalant ❑

IgE 36 - Eastern Combo ❑

IgE 36 - Southern Combo ❑

IgE 36 - Western Combo ❑