



Naperville Rehab Clinic

**445 W Jackson Ave
Naperville, IL 60540
(630) 961-1888**

**24024 Brancaster Dr.
Naperville, IL 60564
(630) 961-1886**

Patient Name: _____ Male _____ Female _____
First Last Middle Initial (check one)

Home Address: _____ Home Phone: () _____
Work Phone: () _____

City: _____ State: _____ Zip: _____

Marital Status: M _____ S _____ D _____ W _____ Cell Phone: () _____

Email: _____

Date of Birth: _____ Age: _____ Social Security #: _____
Driver's License #: _____

How did you hear about us? _____

Primary Insurance	Phone
Address	ID#:
City/State/Zip	Group #
Insured's Name	Date Of Birth ____/____/____
Relationship to Patient	
Insured's Employer	Phone

Secondary Insurance	Phone
Address	Policy #
City/State/Zip	Group #
Insured's Name	Date Of Birth ____/____/____

Assignment of Benefits/Release Of Information:

I authorize payment of insurance benefits directly to Naperville rehab Clinic. 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 Naperville Rehab Clinic 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 Naperville Rehab Clinic. I consent to receive treatment by Naperville Rehab Clinic. I have also read and understand the privacy policies of Naperville Rehab Clinic and my privacy rights under those policies.

PATIENT SIGNATURE

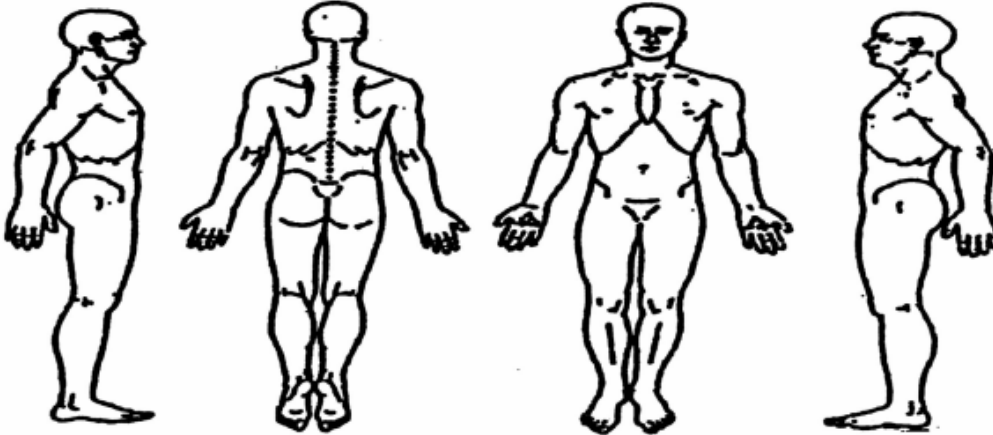
DATE

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____

