



**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

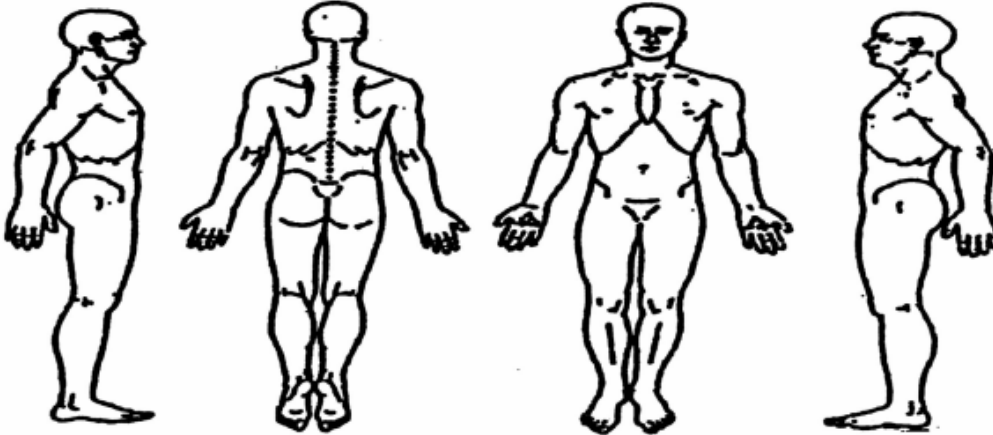
\_\_\_\_\_  
DATE

# 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 \_\_\_\_\_



1. What was the date of the injury? \_\_\_\_\_
2. What time did the injury occur? \_\_\_\_\_
3. What is the name of your employer? \_\_\_\_\_
4. What is the street address of your employer? \_\_\_\_\_
5. What is the City, State, and Zip of your employer? \_\_\_\_\_
6. What is the name of your attorney? \_\_\_\_\_
7. What is the street address of your employer? \_\_\_\_\_
8. What is the City, State, and Zip of your attorney? \_\_\_\_\_
9. Please describe your incident in a few sentences: \_\_\_\_\_
  
10. Did you report the incident to your supervisor? \_\_\_\_\_
11. What is your Supervisor's name? \_\_\_\_\_
12. Did your employer send you to a doctor? If yes, please provide the doctor's name  
\_\_\_\_\_
13. Did you go to a doctor on your own? If yes, please provide the doctor's name  
\_\_\_\_\_
14. Are there any other problems that affect your employment?  
\_\_\_\_\_
15. Does your job cause you to favor one side of your body? \_\_\_\_\_
16. Before the injury, were you capable of performing equal work with others your age?  
\_\_\_\_\_
18. Have you injured this area before? -yes                      - no