

**STERN CHIROPRACTIC
Practice Member Information Form**

Practice Member's Name: _____
Last First Middle

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Please check the phone number(s) where we may contact you/leave a message:

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

Email Address: _____ Best time/place to contact you: _____

Marital Status: _____ Sex: _____ Birth Date: ___/___/___ Age: _____

Patients SS#: _____ - _____ - _____ Drivers License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Occupation: _____

Children's Names and Ages: _____

If Minor: Mother's Name: _____ Father's Name: _____

Family Doctor's Name: _____ Phone: () _____

Whom may we thank for referring you? _____

I have completed the above information to the best of my knowledge. A photocopy of this authorization is to be considered as valid as original. This authorization will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges and fees and that they are due at the time of service.

Signature of Practice Member

_____/_____/_____
Date

Information to Help Us Help You

Which answer best describes your own current ideas and values toward health?

- CONDITION** – I consult a doctor when I have a problem/symptom & discontinue when the symptom is gone.
- PREVENTION** – I try to eat healthy, exercise & seek care to avoid sickness & disease.
- WELLNESS** – I actively pursue a healthy lifestyle (diet, exercise, vitamins, meditation...) to be the best I can be.

To help us better serve you, please check the best answer for each statement below (your initial gut reaction):

1. Do you feel more introverted or extroverted 2. Are you more people oriented or task oriented
3. Using numbers 1-4 (1 is most like you, 4 is least like you) grade the following:

___ I want to direct or challenge ___ I like to serve and accommodate others
___ I feel the need to verbalize or interact ___ I need to comply with rules and procedures

Have you ever been to a chiropractor before? Yes No

If Yes, please place a check in the box for the type of chiropractor you saw:

- "Limited Scope" Chiropractor (focuses mainly on neck and back pain)
- "Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)

If Yes, have you been under regular chiropractic care? Yes No Describe: _____

STERN CHIROPRACTIC

Practice Member's Name: _____ Date: _____

Addressing What Brought You into This Office:

Why are you here today? Wellness or a problem? Describe: _____

If you are experiencing a problem, is it ... (check all that apply) (For Wellness skip to bottom 1/2 of this page)

- Sharp Dull/Ache Burning/stabbing Tingling/Numbness Constant Intermittent In one spot Travels

Where is/are the symptom(s)? _____

When did the symptom(s) first start? _____

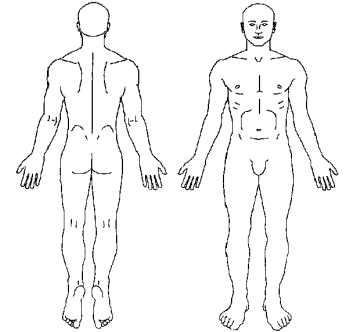
How did it start? _____

It interferes with my: family time work exercise sleep Other _____

Since the symptom(s) started, are they... about the same getting better worse

What makes it better? _____

What makes it worse? _____



Please mark the area(s) of your symptom(s)

Please mark a single vertical line at the point that describes your pain level.

a. Right now: _____
 No Pain Worst Pain Ever Felt

b. Average Pain: _____
 No Pain Worst Pain Ever Felt

What have you done for this condition? Was it of benefit?

Research shows that many of our health challenges that occur in life originate during our developmental years, some starting at or even before birth. Please answer the following questions to the best of your ability.

<u>Childhood – Adult Years</u>	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Were/are you sick frequently?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any falls from heights over 3 ft?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did/do you play sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any prolonged/frequent use of medicine (i.e. Advil, antibiotics, inhalers ...)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you <u>ever</u> been in an accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you exercises regularly?	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 0-10, describe your level of stress (0 = none → 10 = extreme). _____ Occupational _____ Personal

Other doctors you have seen for this condition:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

STERN CHIROPRACTIC

Practice Member's Name: _____ Date: _____

Have you made any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

What lesson(s) have you taken home from your healing process to date?

Addressing Your Lifestyle:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take high quality supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Diet

Please grade these dietary selections according to the following scale:

D - Consume daily | **FD** - Consume a few times per day | **W** - Consume weekly | **FW** - Consume a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume monthly | **O** - Do not consume at all

Fast Food	Organic foods	Whole Grains	Following Diet Program
Fried Foods	Raw Vegetables	Poultry	Premade Diet meals
Soda	Cooked or canned vegetables	Fish/Seafood	Meal Replacement Shakes
Refined Sugar	Fruit	Lean Meats	Coffee
Artificial Sweeteners	Water	Dairy	Other: _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, postures, lack of exercise, etc.)

- a. _____
- b. _____
- c. _____

STERN CHIROPRACTIC

Practice Member's Name: _____ **Date:** _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/meds, etc.)

- a. _____
- b. _____
- c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

- a. _____
- b. _____
- c. _____

On a scale of 0-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work: _____ At home: _____ At play: _____

On a scale of 0-10, (0 being very poor and 10 being excellent) please describe your:

Eating habits: _____ Exercise habits: _____ Sleep: _____ General health: _____ Mind set: _____

How do you grade your physical health?

Excellent Good Fair Poor Getting better Getting worse

How do you grade your emotional/mental health?

Excellent Good Fair Poor Getting better Getting worse

Is there anything else you can tell us to help us to better understand you and your current life situation?

Why are you here Now (what was the motivation that got you to act now?)

STERN CHIROPRACTIC

Practice Member's Name: _____ Date: _____

Health History Questionnaire

Please put a (✓) next to conditions you have currently and a "P" for conditions you have had in the past.

<p>General</p> <p>1 ___ Fever 2 ___ Chills 3 ___ Night Sweats 4 ___ Loss of Sleep 5 ___ Fatigue 6 ___ Nervousness 7 ___ Weight Loss/Gain 8 ___ Allergies 9 ___ Bleeding Problems 10 ___ Anemia 11 ___ Diabetes 12 ___ Cancer 13 ___ Thyroid Disease 14 ___ High Cholesterol 15 ___ Osteoporosis 16 ___ Alcoholism 17 ___ Drug Abuse</p> <p>Eyes, Ears, Nose, & Throat</p> <p>18 ___ Poor Vision 19 ___ Pain in Eye(s) 20 ___ Deafness/Difficulty Hearing 21 ___ Nosebleeds 22 ___ Nose Problems 23 ___ Sinus Trouble 24 ___ Dental Problems 25 ___ Hoarseness</p> <p>Gastrointestinal</p> <p>26 ___ Poor Appetite 27 ___ Poor Digestion 28 ___ Difficulty Swallowing 29 ___ Belching or Gas 30 ___ Frequent Nausea 31 ___ Vomiting Blood 32 ___ Pain over Abdomen 33 ___ Ulcer 34 ___ Black or Bloody Stool 35 ___ Liver Problems 36 ___ Gall Bladder Problems 37 ___ Jaundice 38 ___ Hernia 39 ___ Diarrhea 40 ___ Constipation 41 ___ Hemorrhoids 42 ___ Appendicitis</p> <p>Respiratory</p> <p>43 ___ Difficulty Breathing 44 ___ Chronic Cough 45 ___ Coughing-up Phlegm 46 ___ Coughing-up Blood 47 ___ Wheezing/Asthma 48 ___ Pneumonia 49 ___ Tuberculosis</p>	<p>Cardiovascular</p> <p>50 ___ Irregular Heartbeat 51 ___ High Blood Pressure 52 ___ Pain in Chest 53 ___ Heart Trouble 54 ___ Ankle Swelling 55 ___ Varicose Veins 56 ___ Stroke</p> <p>Genitourinary</p> <p>57 ___ Frequent Urination 58 ___ Painful Urination 59 ___ Blood in Urine 60 ___ Urinary Infection 61 ___ Kidney Disease 62 ___ Inability to Control Urine 63 ___ Difficulty Starting Urine Flow 64 ___ Get up Frequently at Night to Urinate 65 ___ Breast Swelling or Pain 66 ___ Venereal Disease 67 ___ Sexual Dysfunction</p> <p>Skin</p> <p>68 ___ Itching/Dry Flaky 69 ___ Bruising Easily 70 ___ Change in Mole(s) 71 ___ Skin Cancer</p> <p>Male Only</p> <p>72 ___ Testicular Swelling/Pain 73 ___ Prostate Problems</p> <p>Female Only</p> <p>74 ___ Painful Periods 75 ___ Excessive Flow 76 ___ Irregular Cycles 77 ___ Vaginal Burning/Itching 78 ___ Hot Flashes 79 Date Last Period Began _____</p> <p>80 Date of Last PAP Test _____</p> <p>Neurological</p> <p>81 ___ Weakness 82 ___ Twitching 83 ___ Tremors 84 ___ Headaches 85 ___ Fainting 86 ___ Dizziness 87 ___ Convulsions 88 ___ Epilepsy 89 ___ Numbness/Tingling 90 ___ Arm/Leg Pain 91 ___ Mental Disorder</p>	<p>Musculoskeletal</p> <p>92 ___ Neck Stiffness/Pain 93 ___ Pain Between Shoulder Blades 94 ___ Low Back Pain 95 ___ Swollen Joints 96 ___ Stiff/Painful Joints 97 ___ Muscle Aches/Soreness 98 ___ Spinal Curvature 99 ___ Arthritis</p> <p>Habits/Exercise</p> <p>100 ___ Smoking _____ packs/day 101 ___ Alcohol _____ drinks/week 102 ___ Recreational Drug Use 103 Times per week you exercise _____</p> <p>Family Medical History Include information on brothers, sisters, parents and grandparents (not yourself)</p> <p>104 ___ Diabetes 105 ___ Thyroid Disease/Goiter 106 ___ Kidney Disease 107 ___ High Blood Pressure 108 ___ Heart Disease 109 ___ Cancer 110 ___ Muscle, Bone or Nerve Disease 111 ___ Other _____</p> <p>_____</p> <p>_____</p> <p>Other</p> <p>112 List any medical conditions you have (even if listed above): _____ _____ _____ _____ _____</p> <p>113 List all Surgeries/Hospitalizations you have had: _____ _____ _____</p> <p>114. list all Vitamins/Supplements/Herbs you are currently taking: _____ _____ _____ _____</p>
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115. Please list all medications you are currently taking and why you are taking them: _____



OUTCOME ASSESSMENT QUESTIONNAIRE

Name _____ Date: _____

Our goal is to give you the highest quality health care imaginable. In addition to the “objective” tests the doctor will evaluate, we would like to find out more about your “experience.” As we correct the subluxations or nerve interference and you make appropriate lifestyle changes we find that the majority of our practice members not only “feel better” but also have some “unexpected improvements” in their overall health, well being and quality of life!

Health Concerns: Please rate your health concerns on a 0-10 scale; in which 10 is BEST and 0 is WORST imaginable	Initial Exam	Re-Exam 2	Re-Exam 3	Re-Exam 4
1.				
2.				
3.				
4.				
Any new health concerns since last evaluation: 10 = best, 0 = worst				
1.				
2.				
I would rate the overall movement and flexibility in my neck 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my mid back 10 = flexible, 0 = rigid				
I would rate the overall movement and flexibility in my low back 10 = flexible, 0 = rigid				
I am able to notice tension and release it in my body. 10 is I can completely notice tension and release it, 0 is not at all				
My overall posture & ease in standing straight 10 = great, 0 = terrible				
I sleep deep and wake up feeling rested 10 = rested, 0 = tired				
I feel I have energy for all my daily activities 10 = a lot, 0 = none				
I feel emotions like anger, depression, unhappy, hopeless 10 = no anger , 0 = severe anger				
I feel emotions like joy, happiness, gratitude, hope 10 = a lot of joy, 0 = no joy				
I notice a deeper awareness of what my body wants from me in relation to (sleep, rest, exercise, movement, diet) since receiving adjustments 10 = yes, 0 = no				
I have less illness and recover faster. 10 = yes, 0 = no				
My self-perception is 10 = excellent, 0= terrible				
My spiritual connection 10 = excellent , 0= none NA= not applicable				
My diet is 10= excellent, 0 = terrible				
My exercise is 10 = excellent, 0 = none				
My strategies to deal with emotional stress 10 = excellent, 0 = terrible				
On the 1-100 scale, 50 being Symptoms, I believe I am now at:				
On the 1-100 scale, 50 being Symptoms, I would like to be at:				
My main goal is: 0 = still cannot do it, 10 = fully reached goal				
New main goal is (later in care): 0 = cannot do it, 10 = fully reached goal				

Stern Chiropractic Office Policies

Welcome to Stern Chiropractic - Stern Chiropractic would like to provide you with the best possible care. Dr. Stern will conduct a thorough history and physical examination to decide if he can assist you. If Dr. Stern does not believe that your condition will respond to chiropractic and/or acupuncture care, he will refer you to another health care provider, if appropriate.

Fee and Payment Policy - Payment is due in full at time of service. The office accepts cash (please try to have exact change), personal check and charge (Visa & MC). The office charges \$25 for any returned check. If fees for service are not paid in a timely manner, a late payment penalty (ies) will be assessed. If you (the patient) do not pay your bill on a timely basis and the office must pursue collections efforts, you will be responsible for all fees associated with said collections. There is a \$20 minimum for credit card charges.

Cancellation Policy – Please notify the office as soon as possible if you will be unable to keep your appointment. Appointments not cancelled at least 24 hours in advance will be billed to the patient/responsible party at the value of the visit missed.

Payment Agreement

I (the patient/responsible party) understand that I am responsible for all charges in full at the time of service and if I do not pay my bill on a timely basis, I will be financially responsible for all charges and fees associated with late payment.

Insurance

This office will provide you with the appropriate billing information for you to submit to your insurance company for reimbursement.

The following signature demonstrates an understanding and acceptance of the office policies of Stern Chiropractic.

Practice Member/Guardian (if applicable) Signature

Date

Stern Chiropractic reserves the right to change office policies as needed without notice.

STERN CHIROPRACTIC, LTD.

**PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS**

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Stern Chiropractic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Stern Chiropractic to provide treatment to me, and also necessary for Stern Chiropractic to obtain payment for treatment and to carry out health care operations. Stern Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. Stern Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Stern Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders, communications from this office, birthday greetings, recall notice, billing statements and newsletters that will be used by Stern Chiropractic: a) a postcard or letter mailed to me at the address provided by me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; and c) emailing me at the email address provided by me.
4. Stern Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Stern Chiropractic to treat me and obtain payment for that treatment, and as necessary for Stern Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that Stern Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Stern Chiropractic is not required to agree to any restrictions that I have requested. If Stern Chiropractic agrees to a requested restriction, then the restriction is binding on Stern Chiropractic.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Stern Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, Stern Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then Stern Chiropractic will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Relationship

Date Signed ____/____/____

Witness: _____

General information					
DOCTOR'S NAME					
DATE(S) OF FILMS			DATE OF INJURY		
<input type="checkbox"/> CASH	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> WORK/COMP	<input type="checkbox"/> PERS INJURY	<input type="checkbox"/> AUTO ACCIDENT
PATIENT / INSURED INFORMATION			PLEASE PRINT/TYPE		
REQUIRED INFO	PATIENT		INSURED		
NAME					
STREET					
CITY					
STATE & ZIP					
TELEPHONE					
SOC SEC #					
DATE OF BIRTH					
AGE & SEX					
RELATION TO INSURED: () SELF () SPOUSE () CHILD () OTHER					
INSURANCE INFORMATION			PLEASE PRINT/TYPE		
REQUIRED INFO	PRIMARY INSURANCE		SECONDARY INSURANCE		
COMPANY NAME					
STREET					
CITY					
STATE & ZIP					
TELEPHONE					
POLICY #					
GROUP #					
I.D. #					
WORK. COMP. / ATTORNEY INFORMATION			PLEASE PRINT/TYPE		
REQUIRED INFO	WORKER'S COMP		ATTORNEY		
EMPLOYER/ATTORNEY					
STREET					
CITY					
STATE & ZIP					
TELEPHONE					
FINDINGS / CONCERNS			PLEASE PRINT/TYPE		
SYMPTOMS / HISTORY / EXAM			CLINICAL CONCERNS		

X-RAY ASSIGNMENT AGREEMENT AND CONSENT

I understand that my doctor is submitting my x-rays to Radiology Diagnostics, LLC for primary radiological interpretation and report by a specialist. I also understand that the fee for such services will be submitted to my insurance company, healthcare carrier, attorney or worker's compensation carrier for payment. If I am paid directly by an insurance carrier or through a legal settlement, I will be responsible for the amount paid. If Radiology Diagnostics, LLC does not receive a lien, or if Radiology Diagnostics, LLC does not receive a reply to a case status information request from my attorney, I will be billed for the amount of service. Once Radiology Diagnostics, LLC receives a reply from the attorney, I will stop being billed.

I also give my consent to Radiology Diagnostics, LLC use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance on this consent. I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Radiology Diagnostics, LLC which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. **My signature authorizes the release of medical information and also authorizes the assignment of benefits to:**

Radiology Diagnostics, LLC

In the event my insurance company or attorney sends payment of services to me, I agree to promptly remit such payment to Radiology Diagnostics, LLC

Date

Patient Signature

Print Name