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:_____

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? _____

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: _____

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

Maternity Information

Why is this form important?

As a family chiropractic office, we focus on your family's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your children the opportunity of improved health potential and wellness services.

Daily, we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your health potential.

Pregnancy:

of previous pregnancies:____ Where there any problems?_____

Have there been any complications during the pregnancy?_____

Have you been on any medications, prescription or over-the-counter? ○ Yes ○ No Why?_____

Did you or dad smoke during pregnancy? □ Yes □ No Who?_____

Has the baby ever been in the Breech position? □ Yes □ No How Many Ultra Sounds were performed?_____

How far along are you:_____weeks

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 ½ 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? _____

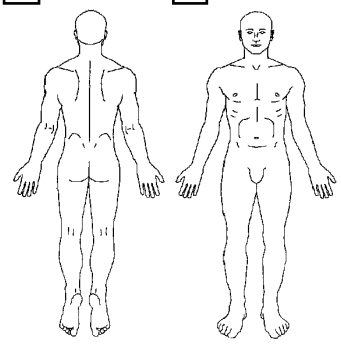
How did it start? _____

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.

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

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?

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Practice Member's Name:_____**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 ◯ No ◯ Maybe ◯
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ◯ No ◯ Maybe ◯
Would you take high quality supplements if indicated?	Yes ◯ No ◯ Maybe ◯
If specific exercises or stretching would help would you consider adding them to your program?	Yes ◯ No ◯ Maybe ◯
If reducing stress would help would you like to know ways to reduce stress?	Yes ◯ No ◯ Maybe ◯

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. _____

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. _____

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Practice Member's Name:_____ Date:_____

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?

_____

_____

_____

_____

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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.

General
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

Eyes, Ears, Nose, & Throat
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

Gastrointestinal
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

Respiratory
43 ___ Difficulty Breathing
44 ___ Chronic Cough
45 ___ Coughing-up Phlegm
46 ___ Coughing-up Blood
47 ___ Wheezing/Asthma
48 ___ Pneumonia
49 ___ Tuberculosis

Cardiovascular
50 ___ Irregular Heartbeat
51 ___ High Blood Pressure
52 ___ Pain in Chest
53 ___ Heart Trouble
54 ___ Ankle Swelling
55 ___ Varicose Veins
56 ___ Stroke

Genitourinary
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 Lumps or Pain
66 ___ Venereal Disease
67 ___ Sexual Dysfunction

Skin
68 ___ Itching/Dry Flaky
69 ___ Bruising Easily
70 ___ Change in Mole(s)
71 ___ Skin Cancer

Male Only
72 ___ Testicular Swelling/Pain
73 ___ Prostate Problems

Female Only
74 ___ Painful Periods
75 ___ Excessive Flow
76 ___ Irregular Cycles
77 ___ Vaginal Burning/Itching
78 ___ Hot Flashes
79 Date Last Period Began

_____
80 Date of Last PAP Test

_____

Neurological
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

Musculoskeletal
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

Habits/Exercise
100 ___ Smoking _____ packs/day
101 ___ Alcohol _____ drinks/week
102 ___ Recreational Drug Use
103 Times per week you exercise _____

Family Medical History
Include information on brothers, sisters, parents and grandparents (not yourself)
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 _____

_____

Other
112 List any medical conditions you have (even if listed above):

_____

_____

_____

_____

_____

113 List all Surgeries/Hospitalizations you have had:

_____

_____

_____

114. list all Vitamins/Supplements/Herbs you are currently taking:

_____

_____

_____

_____

115. Please list all medications you are currently taking and why you are taking them: _____

_____

_____

_____

STERN CHIROPRACTIC
Where Families & Wellness Come Together

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121 McHenry Rd., Buffalo Grove, IL. 6008
E-mail: docstern@SternChiro.com
Website: www.SternChiro.com

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	Complete NOW	Re-Exam Date:_____	Re-Exam Date:_____	Re-Exam Date:_____
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				
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 happy & grateful 10 = everyday, 0 = never				
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	X			
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	X			

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 Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed _____ Witness: _____

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.