STERN CHIROPRACTIC


Pediatric Intake Form

Child's Name:_____ Birth Date:___/___/___ Age:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Child's SS#:_____ Sex:___ Parents Names:_____

Please check the phone number(s) where we may contact you/leave a message:
☐Home: _____ ☐ Cell: _____ ☐ Work: _____

Email:_____ Siblings (Names/Ages):_____

Reason for today's visit:_____

Whom may we thank for referring you?_____

Family Doctor's Name:_____ Phone: _____

Family Doctor's Address:_____
Would you like me to keep your family doctor informed about your treatment? ☐Yes ☐ No

Financially Responsible Party: ☐Insured Party ☐Other:_____
Responsible Party Address (if different than above):
Address:_____ Apt. #:_____

City:_____ State:_____ Zip Code:_____
Please check the phone number(s) where we may contact you/leave a message:
☐Home: _____ ☐Cell: _____ ☐Work: _____

Policy Holder's Name:_____ SS#:_____

Relation to Policy Holder: ☐Dad ☐Mom ☐Other:_____

Insurance Company:_____ Phone #: _____

Employer of Policy Holder:_____

ID #:_____ Group/Plan #:_____ Policy Holders Birth Date:___/___/___

I have completed the above information to the best of my knowledge. I authorize Stern Chiropractic to release any information concerning this child's health and health care services to my insurance companies. I hereby assign all medical benefits to which I am entitled, private insurance, Medicare, and any other insurance program to Stern Chiropractic and I direct that payment be made directly Stern Chiropractic, 121 McHenry Rd., Buffalo Grove, IL 60089. A photocopy of this assignment is to be considered as valid as original. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges, whether or not paid/covered by said insurance, and that I will be responsible for any amounts uncollected by Stern Chiropractic.

_____ _____
Signature of Parent/Guardian Date


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Pediatric Health History

Why is this form important?

As a family chiropractic office, we focus on your child'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 child the opportunity of improved health potential and wellness services.

Addressing the issues that brought you to our office

If your child has no symptoms or complaints, and is here for wellness services, please check ☐; otherwise please briefly describe the problem (what's wrong, what part of his/her body) including how it is affecting your child.

_____

_____

When did it start?_____ How did it happen?_____

If he/she is experiencing pain, is it: ☐Sharp ☐ Dull ☐ Travels ☐ Comes and Goes ☐Constant?

Since the problem started, is it: ☐About the same ☐ Getting worse ☐Getting better?

What makes it worse?_____ What makes it better?_____

It interferes with: ☐School ☐Sleep ☐ Walking ☐ Sitting ☐ Activities/other:_____

Have you seen anyone else for this problem:_____

List any medical conditions:_____

List all medications your child is taking:_____

List all surgeries your child has had:_____

List all vitamins and supplements your child is taking:_____

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 child's health potential.

Pregnancy:

of previous pregnancies:____ Where there any problems?_____

Were there <u>any</u> complications during the pregnancy?_____

Was mom on <u>any</u> medications, prescription or over-the-counter? ☐Yes ☐No Why?_____

Did mom or dad smoke during pregnancy? ☐Yes ☐No Who?_____

Was the baby ever in the Breech position? ☐Yes ☐No How Many Ultra Sounds were performed?_____

Duration of Gestation:_____weeks

Birth and Delivery:

Where was the baby born? ☐Home ☐Hospital ☐Birthing Center ☐ Other:_____

Was the delivery: ☐Vaginal ☐C-section If not vaginal, why?_____

Were any devices used? ☐ Forceps ☐ Vacuum APGAR Scores: Initial ____ 5 minutes___

How long was the labor?_____ How long was the delivery?_____ Any problems?_____

Please turn over and complete other side

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Was labor induced with medications? ☐yes ☐No Was an epidural administered? ☐Yes ☐ No

Any evidence of birth trauma: bruises, odd shaped head, stuck in burth canal, fast or excessively long birth, respiratory depression, cord around neck, other ☐ Yes ☐No If yes, describe:_____

Infancy:

Is/was the baby breastfed? ☐ Yes ☐ No If yes, how long?_____ Any problems?_____

Was the infant vaccinated? ☐ Yes ☐No If yes, any problems?_____

Was there any immediate or ongoing medical care or use of medicines? ☐Yes ☐No If yes, what?_____

Did the infant suffer any traumas i.e. falls or car accidents? ☐Yes ☐No

Did the baby meet all developmental milestones? ☐Yes ☐ No Explain:_____

Has the infant been under regular chiropractic care? ☐yes ☐No

Childhood Years:

Did the child meet all developmental milestones? ☐Yes ☐No Explain:_____

Did the child have any childhood illnesses? ☐Yes ☐No Explain:_____

Does the child play sports? ☐Yes ☐ No Which sports:_____

Has the child had any surgery? ☐Yes ☐No Explain:_____

Has the child fallen from a height over 3 ft.? ☐Yes ☐No Explain:_____

Was the child involved in <u>any</u> car accidents? ☐Yes ☐No Explain:_____

Has there been any prolonged use of meds? ☐Yes ☐ No Explain:_____

Has the child suffered emotional traumas? ☐Yes ☐No Explain:_____

Has the child had any behavioral problems? ☐Yes ☐No Explain:_____

Please give us any other health information you feel would be helpful:_____

_____

The statements made on this form are accurate to the best of my knowledge and I request and give consent to this office to examine and provide chiropractic care to my child.

_____ ____/____/____

Signature of Parent or Guardian Date

Please turn over and complete other side

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Practice Member's Name: _____ Date: _____

Health History Questionnaire

Please put a (x) 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 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 - For all initial visits, payment is due in full at time of service. If Stern Chiropractic is contracted with your insurance company, payment is due in full until benefits can be verified, if allowable by your insurance company, and then any deductible and co-pay are due at time of visit. If Stern Chiropractic is not contracted with your insurance company, payment is due in full at time of visit. 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 practice member or financially responsible party) 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 at the value of the visit missed and cannot be billed to, nor reimbursed by, insurance.

Payment Agreement
I (the patient/responsible party) understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges including charges for services not covered by my insurance company. I also understand that if Stern Chiropractic is not billing my insurance, I am responsible for all charges at the time of service.

Insurance
This office will process your insurance forms upon request if we are affiliated with your insurance carrier, otherwise we will provide you with the appropriate billing information to submit yourself. We will provide sufficient information to your carrier/you to obtain payment for your care. We have found that, in some instances, however insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full unless Stern Chiropractic is a part of your insurance plan and this is not allowed.

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 CARE, 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 care to me/this person, and also necessary for Stern Chiropractic to obtain payment for care 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/this person at the address provided by me; b) telephoning my home, cell and/or work and leaving a message on my answering machine or with the individual answering the phone; and c) emailing me/this person 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 care provided to me) in order for Stern Chiropractic to provide care to me/this person and obtain payment for that care, 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 care, 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 continue to provide care to me/this person.
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 provide care to 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: _____