STERN CHIROPRACTIC

**Practice Member Information Form**

Practice Member's Name:_____ Birth Date:___/___/___ Age:_____

Address:_____ Apt. #:_____

City:_____ State:_____ Zip Code:_____

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

☐Home: _____ ☐Cell: _____ ☐Work: _____

SS#: _____ Marital Status:_____ Sex:___

Email Address:_____

Employer:_____ Occupation:_____

Spouse's Name:_____ Occupation:_____

Children's Names and Ages:_____

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

Family Doctor's Name:_____ Phone: _____

Family Doctor's Address:_____

Would you like me to keep your family doctor informed about your care? ○Yes ○No

**Referred By**:_____

Financially Responsible Party: ☐Practice Member ☐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: ☐Self ☐Spouse ☐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 my/this person'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 Practice Member Date

_____ _____

Signature of Responsible Party Date

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?** _____

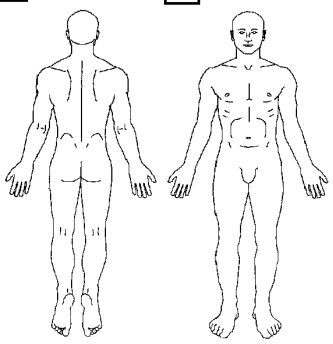
**How did it start?** _____

**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 (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
Where Families & Wellness Come Together

Tel: (847) 537-2225 (BACK
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 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: _____

# 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.

# ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (844) 283-4163

PATIENT _____ CLINIC Stern Chiropractic FILM DATE _____

AGE____ SEX M☐ F☐ SOCIAL SECURITY#_____/_____/_____ DATE OF BIRTH _____

PATIENT ADDRESS_____CITY_____STATE_____ZIP_____

## X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE:_____ DATE:_____

WITNESS:_____

FOR OFFICE USE ONLY

**PATIENT HISTORY**

PATIENT PRESENTATION_____

_____

TRAUMA? YES ☐ NO ☐ EXPLAIN_____

PAST MEDICAL HISTORY_____

_____

MALIGNANCY? YES ☐ NO ☐ DETAILS_____

DIAGNOSIS/CONCERNS/QUESTIONS[NO ICD CODES PLEASE]_____

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE

# ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424 (844) 283-4163

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**CASH (no insurance)**◯_____ **MEDICARE ONLY** ◯_____ **MEDICAID ONLY**◯_____

**STANDARD**

**NEED NON-PARTICIPATING PROVIDER INSURANCE NAME & BILLING ADDRESS**
***PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).**

| INSURANCE NAME & BILLING ADDRESS PRIMARY | | | INSURANCE NAME & BILLING ADDRESS SECONDARY | | |
|---|---|---|---|---|---|
| CARRIER | TELEPHONE | | CARRIER | TELEPHONE | |
| ADDRESS | | | ADDRESS | | |
| CITY | STATE | ZIP | CITY | STATE | ZIP |
| RELATIONSHIP TO INSURED SELF◯ SPOUSE◯ CHILD◯ OTHER◯_____ | | | RELATIONSHIP TO INSURED SELF◯ SPOUSE◯ CHILD◯ OTHER◯_____ | | |
| INSURED NAME | INSURED DATE OF BIRTH | | INSURED NAME | INSURED DATE OF BIRTH | |
| INSURED SOCIAL SECURITY # | INSURED ID # | | INSURED SOCIAL SECURITY # | INSURED ID # | |
| INSURED GROUP # | BCBS 3 LTR PREFIX | | INSURED GROUP # | BCBS 3 LTR PREFIX | |
| INSURED EMPLOYER | TELEPHONE | | INSURED EMPLOYER | TELEPHONE | |

**AUTO ACCIDENT/PI/WORKERS' COMPENSATION**

**RELATED TO EMPLOYMENT? YES ☐ NO ☐**
**AUTO ACCIDENT? YES ☐ NO ☐**
**OTHER? YES ☐ NO ☐**

**DATE OF INJURY**_____

| W/C CARRIER OR AUTO CARRIERS | | | ATTORNEY NAME & BILLING ADDRESS | | | |
|---|---|---|---|---|---|---|
| CARRIER | TELEPHONE | | ATTORNEY NAME | TELEPHONE | | |
| INSURANCE ADDRESS | | | ATTORNEY ADDRESS | | | |
| CITY | STATE | ZIP | CITY | STATE | ZIP | |
| RELATIONSHIP TO INSURED SELF☐ SPOUSE☐ CHILD☐ OTHER_____ | | | *PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS USE ADDITIONAL PAPER IF NECESSARY | | | |
| CLAIM NUMBER | INSURED NAME | | IF W/C: EMPLOYER ADDRESS | CITY | ST | ZIP |
| IF PI: ADJUSTERS NAME | ADJ: TELEPHONE | | IF W/C: ALLOWED DIAGNOSIS ICD-9 CODES | | | |

**PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE**