

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: \_\_\_\_\_

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 Part 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: \_\_\_\_\_

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 Your Lifestyle:

Table with 2 columns: Question and Response (Yes, No, Maybe). Questions include: 'Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?', 'If dietary changes are indicated would you be willing to make changes in your diet?', 'Would you take high quality supplements if indicated?', 'If specific exercises or stretching would help would you consider adding them to your program?', 'If reducing stress would help would you like to know ways to reduce stress?'.

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

Table with 4 columns: Dietary Item, Organic foods, Whole Grains, Following Diet Program. Items include: Fast Food, Fried Foods, Soda, Refined Sugar, Artificial Sweeteners, Organic foods, Raw Vegetables, Cooked or canned vegetables, Fruit, Water, Whole Grains, Poultry, Fish/Seafood, Lean Meats, Dairy, Premade Diet meals, Meal Replacement Shakes, Coffee, 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. \_\_\_\_\_

STERN CHIROPRACTIC

**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?

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

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# STERN CHIROPRACTIC

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.

<p><b>General</b></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><b>Eyes, Ears, Nose, &amp; Throat</b></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><b>Gastrointestinal</b></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><b>Respiratory</b></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><b>Cardiovascular</b></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><b>Genitourinary</b></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 Lumps or Pain                  66 ___ Venereal Disease                  67 ___ Sexual Dysfunction</p> <p><b>Skin</b></p> <p>68 ___ Itching/Dry Flaky                  69 ___ Bruising Easily                  70 ___ Change in Mole(s)                  71 ___ Skin Cancer</p> <p><b>Male Only</b></p> <p>72 ___ Testicular Swelling/Pain                  73 ___ Prostate Problems</p> <p><b>Female Only</b></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><b>Neurological</b></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><b>Musculoskeletal</b></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><b>Habits/Exercise</b></p> <p>100 ___ Smoking _____ packs/day                  101 ___ Alcohol _____ drinks/week                  102 ___ Recreational Drug Use _____                  103 ___ Times per week you exercise _____</p> <p><b>Family Medical History</b></p> <p>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><b>Other</b></p> <p>112 List any medical conditions you have (even if listed above):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>113 List all Surgeries/Hospitalizations you have had:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>114. list all Vitamins/Supplements/Herbs you are currently taking:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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115. Please list all medications you are currently taking and why you are taking them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Stern Chiropractic - SF 36 Health Survey

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INSTRUCTIONS:** This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

Excellent	<input type="checkbox"/>
Very Good	<input type="checkbox"/>
Good	<input type="checkbox"/>
Fair	<input type="checkbox"/>
Poor	<input type="checkbox"/>

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

Much better than one year ago	<input type="checkbox"/>
Somewhat better now than one year ago	<input type="checkbox"/>
About the same as one year ago	<input type="checkbox"/>
Somewhat worse now than one year ago	<input type="checkbox"/>
Much worse now than one year ago	<input type="checkbox"/>

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Please circle **one** number on each line.)

<u>Activities</u>	Yes, Limited A Lot	Yes, Limited A Little	Not Limited At All
3(a) <u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b) <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c) <u>Lifting or carrying groceries</u>	1	2	3
3(d) <u>Climbing several flights of stairs</u>	1	2	3
3(e) <u>Climbing one flight of stairs</u>	1	2	3
3(f) <u>Bending, kneeling, or stooping</u>	1	2	3
3(g) <u>Waling more than a mile</u>	1	2	3
3(h) <u>Walking several blocks</u>	1	2	3
3(i) <u>Walking one block</u>	1	2	3
3(j) <u>Bathing or dressing yourself</u>	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Please circle **one** number on each line.)

	Yes	No
4(a) <u>Cut down on the amount of time</u> you spent on work or other activities	1	2
4(b) <u>Accomplished less than you would like</u>	1	2
4(c) <u>Were limited in the kind of work or other activities</u>	1	2
4(d) <u>Had difficulty performing the work or other activities</u> (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)? (Please circle **one** number on each line.)

	Yes	No
5(a) <u>Cut down on the amount of time</u> you spent on work or other activities	1	2
5(b) <u>Accomplished less than you would like</u>	1	2
5(c) <u>Didn't do work or other activities as carefully as usual</u>	1	2

Stern Chiropractic - SF 36 Health Survey

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

Not at all

Slightly

Moderately

Quite a bit

Extremely

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7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

None

Very mild

Mild

Moderate

Severe

Very Severe

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8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

Not at all

A little bit

Moderately

Quite a bit

Extremely

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9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

(Please circle one number on each line.)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
9(a) Did you feel full of life?	1	2	3	4	5	6
9(b) Have you been a very nervous person?	1	2	3	4	5	6
9(c) Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d) Have you felt calm and peaceful?	1	2	3	4	5	6
9(e) Did you have a lot of energy?	1	2	3	4	5	6
9(f) Have you felt downhearted and blue?	1	2	3	4	5	6
9(g) Did you feel worn out?	1	2	3	4	5	6
9(h) Have you been a happy person?	1	2	3	4	5	6
9(i) Did you feel tired?	1	2	3	4	5	6

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10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

All of the time

Most of the time

Some of the time

A little of the time

None of the time

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11. How TRUE or FALSE is each of the following statements for you?

(Please circle one number on each line.)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
11(a) I seem to get sick a little easier than other people	1	2	3	4	5
11(b) I am as healthy as anybody I know	1	2	3	4	5
11(c) I expect my health to get worse	1	2	3	4	5
11(d) My health is excellent	1	2	3	4	5

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

\_\_\_\_\_  
Relationship

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.