

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 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: _____

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

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 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? _____

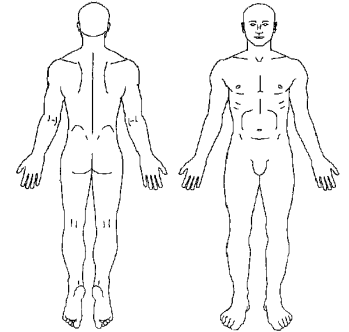
How did it start? _____

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?

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Practice Member's Name: _____ Date: _____

Addressing Your Lifestyle:

Table with 2 columns: Question and Yes/No/Maybe options. 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, 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. _____

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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.

<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 Lumps 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: _____

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 <u>now</u> ? (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 <u>your health now limit you</u> 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)	Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2
3(b)	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2
3(c)	Lifting or carrying groceries	1	2
3(d)	Climbing several flights of stairs	1	2
3(e)	Climbing one flight of stairs	1	2
3(f)	Bending, kneeling, or stooping	1	2
3(g)	Waling more than a mile	1	2
3(h)	Walking several blocks	1	2
3(i)	Walking one block	1	2
3(j)	Bathing or dressing yourself	1	2
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 <u>your physical health</u> ? (Please circle one number on each line.)		
		Yes	No
4(a)	Cut down on the amount of time you spent on work or other activities	1	2
4(b)	Accomplished less than you would like	1	2
4(c)	Were limited in the kind of work or other activities	1	2
4(d)	Had difficulty performing the work or other activities (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 <u>any emotional problems</u> (e.g. feeling depressed or anxious)? (Please circle one number on each line.)		
		Yes	No
5(a)	Cut down on the amount of time you spent on work or other activities	1	2
5(b)	Accomplished less than you would like	1	2
5(c)	Didn't do work or other activities as carefully as usual	1	2

Stern Chiropractic - SF 36 Health Survey

6.	<p>During the <u>past 4 weeks</u>, 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.)</p> <p>Not at all <input type="checkbox"/></p> <p>Slightly <input type="checkbox"/></p> <p>Moderately <input type="checkbox"/></p> <p>Quite a bit <input type="checkbox"/></p> <p>Extremely <input type="checkbox"/></p>						
7.	<p>How much <u>physical</u> pain have you had during the <u>past 4 weeks</u>? (Please tick one box.)</p> <p>None <input type="checkbox"/></p> <p>Very mild <input type="checkbox"/></p> <p>Mild <input type="checkbox"/></p> <p>Moderate <input type="checkbox"/></p> <p>Severe <input type="checkbox"/></p> <p>Very Severe <input type="checkbox"/></p>						
8.	<p>During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)? (Please tick one box.)</p> <p>Not at all <input type="checkbox"/></p> <p>A little bit <input type="checkbox"/></p> <p>Moderately <input type="checkbox"/></p> <p>Quite a bit <input type="checkbox"/></p> <p>Extremely <input type="checkbox"/></p>						
9.	<p>These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. Please give the one answer that is closest to the way you have been feeling for each item.</p> <p>(Please circle one number on each line.)</p>						
		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
10.	<p>During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives etc.) (Please tick one box.)</p> <p>All of the time <input type="checkbox"/></p> <p>Most of the time <input type="checkbox"/></p> <p>Some of the time <input type="checkbox"/></p> <p>A little of the time <input type="checkbox"/></p> <p>None of the time <input type="checkbox"/></p>						
11.	<p>How TRUE or FALSE is <u>each</u> of the following statements for you?</p> <p>(Please circle one number on each line.)</p>						
		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.