STERCHI CHIROPRACTIC

54 W. Countryside Pkwy. Suite D
Yorkville, IL 60560
Office (630)553-8393
Fax (630)553-8395
www.sterchichiropractic.com

CONFIDENTIAL PATIENT INFORMATION

Patient's Legal Name:_____ Today's Date: _____

Address:_____/_____/_____/_____
Number and Street / City / State / Zip

Phone Numbers ☐ Home:_____ ☐ Work:_____
Please check ☑ *preferred primary*
☐ Cell:_____ Cell Carrier:_____ *(used for text reminders)*

Patient's Date of Birth:_____ Patient's Social Security#:_____ Male / Female
Circle

Number of Children:_____ Marital Status: (*circle one*) Married Single Divorced Separated Widowed

Occupation:_____ Full-Time Part-Time (*circle one*) Email:_____

Employer:_____ Address:_____/_____/_____/_____
Number and Street / City / State / Zip

How did you hear about our office?_____ Were you referred? If so, by whom?:_____

Primary Care Physician:_____ _____
Name / City

What is your chief complaint today?_____ Any additional complaints? _____

Emergency Contact's Name:_____ Relation:_____ Phone: _____

In order to comply with federal standards, please answer the following questions:

Preferred Language?
- ☐ English
- ☐ Spanish
- ☐ Other_____

Race?
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ I do not wish to provide this information.
- ☐ Other _____

Ethnicity?
- ☐ I do not wish to provide
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other _____

INSURANCE INFORMATION

Are you currently covered by medical insurance? Yes No (circle one) ***If yes please complete the following***

Name of Primary Insurance:_____ ID #:_____ Group #:_____

Are you currently covered by secondary insurance? Yes No (circle one)

Name of Secondary Insurance:_____ ID #:_____ Group #:_____

Insured/Policy Holder's Information ***If the patient IS the insured, please circle "same" and skip this section.***

Relationship to patient: Same Spouse Parent Step-Parent Other (explain)_____

Policy Holder's Name :_____Policy Holder's Date of Birth:_____

Address:_____/_____/_____/_____
Number and Street / City / State / Zip

Phone Numbers Home:_____ Work:_____ Cell:_____

Policy Holder's Employer:_____ Policy Holder's Social Security#:_____

ACCIDENT/INJURY INFORMATION

Is today's visit due to an accident? Yes or No (circle one) WORK ACCIDENT or AUTO ACCIDENT (circle one)

Date of Accident: _____ ***PLEASE FILL OUT ADDITIONAL ACCIDENT FORMS***

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HEALTH HISTORY

Patient's Name:_____ Date:_____

MEDICATION

Are you taking any medication?

☐ Yes ☐ No *(If you have a written list we can copy it for you.)*

Name	Dosage	Frequency
(example) BYSTOLIC	*10MG*	*1x daily*

VITAMINS/SUPPLEMENTS

Are you taking any Vitamins/Supplements?

☐ Yes ☐ No

Name	Name

ALLERGIES

Do you have any known drug allergies? ☐ Yes ☐ No

Please list all allergies including medications:

_____

_____

_____

PAST SURGERIES

List all past surgeries: None ☐

Year	Procedure

REVIEW OF SYSTEMS

Check ☑ any health problems that pertain to you

General
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain/ loss

Musculoskeletal
- ☐ Known disease
- ☐ Joint Pain
- ☐ Swelling/ stiffness
- ☐ Neck/ back pain
- ☐ Upper extremity pain
- ☐ Lower extremity pain

Eyes
- ☐ Corrective eyewear
- ☐ Eye Pain
- ☐ Visual disturbance
- ☐ Blindness

Ear/ Nose/ Throat/ Mouth
- ☐ Earache
- ☐ Frequent nose bleed
- ☐ Hearing loss
- ☐ Sinus pain
- ☐ Sore throat
- ☐ Tooth/ gum problems

Respiratory
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Fainting spells
- ☐ Palpitations
- ☐ Racing heart rate
- ☐ Swollen ankles

Skin (integumentary system)
- ☐ Open wounds/ sores
- ☐ Rash
- ☐ Psoriasis

Allergy/Immunologic
- ☐ Frequent infections
- ☐ Runny nose/ sneezing
- ☐ Skin sensitivities

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody stools
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Eating Disorder

Genitourinary
- ☐ Bloody urine
- ☐ Incontinence
- ☐ Painful urination

Neurological
- ☐ Dizziness
- ☐ Balance/ Coordination problems
- ☐ Excessive headaches
- ☐ Memory loss or confusion
- ☐ Numbness/weakness
- ☐ Tremors/seizures

Metabolic/Endocrine
- ☐ Excessive thirst/ urination
- ☐ Glandular or hormone problems
- ☐ Heat/cold intolerance

Hematological
- ☐ Bruise easily
- ☐ Easy/ persistent bleeding

Psychiatric
- ☐ Agitation
- ☐ Depression
- ☐ Insomnia
- ☐ Suicidal
- ☐ Bipolar Disorder

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any members of the staff responsible for any errors or omissions that may have been made in the completion of this form.

Signature: _____ Date:_____

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HEALTH HISTORY

Patient's Name:_____ Date:_____

PAST MEDICAL HISTORY

Have you been diagnosed with any of the following problems?

☐Yes ☐ No

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots/DVT
- ☐ Bone Cancer
- ☐ Breast Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High/Elevated Cholesterol
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Lung Cancer
- ☐ Lupus, Skin
- ☐ Lupus, Systemic
- ☐ Lymphoma
- ☐ Mitral Valve Prolapse
- ☐ Multiple Myeloma
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Peripheral Vascular Disease
- ☐ Prostate Cancer
- ☐ Prostate Enlarged
- ☐ Reflux
- ☐ Renal Failure
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Dysfunction
- ☐ Tuberculosis
- ☐ Other: (Explain)_____

_____

LIFESTYLE HABITS

Are you retired? ☐ Yes ☐ No

Do you currently use any of the following tobacco products?

☐ None ☐ Cigarettes ☐ Cigars ☐ Smokeless Tobacco

Give the closest amount of cigarettes you smoke in an average day.

☐ 1/2 Pack ☐ 1 Pack ☐ 1-1/2 Packs ☐ 2 Packs ☐ 3 Packs

Year started smoking _____ **Year stopped smoking** _____

Alcoholic Beverages

(A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.)

☐ None ☐ Light (1-3 drinks/month) ☐ Moderate (4-14 drinks/week)
☐ Abstainer (less than 12 drinks/year) ☐ Heavy (more than 2 drinks/day)

Do you have a dependency or addiction to drugs now or in the past? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Caffeine Use *(coffee, tea, chocolate, cola, other caffeinated drinks)*

☐ None ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Which is your dominant hand? ☐ Right ☐ Left ☐ Neither

Exercise Level *(regularly, for 20 minutes or more)*

☐ No Exercise ☐ 1-2 Times Weekly ☐ 3+ Times Weekly

Home Living Setting *(check all that apply)*

☐ Alone ☐ Mother ☐ Assisted Living ☐ Nursing Home
☐ Spouse ☐ Father ☐ Children ☐ Other :_____

FAMILY HISTORY

Indicate family members who have been diagnosed with any of the following:
(check all that apply)

	Father	Mother	Brother	Sister
None ☐				
Rheumatoid Arthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Bleeding/Clotting Problem	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐

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Patient Acknowledgement & Signature Form

Patient's Name:_____ Date of Birth:_____

* Informed Consent:

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote (occurring at a rate of one in 5.85 million). Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- *Self-administered, over-the-counter analgesics and rest*
- *Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers*
- *Hospitalization*
- *Surgery If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.*

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

*Consent to X-Ray:

I understand that x-rays may be necessary to accurately diagnose and analyze my condition. It is Sterchi Chiropractic's policy to have the x-rays that are taken in the office to be interpreted by a board certified radiologist. **I accept that a $30 fee per series (regions) of x-rays will be charged for the interpretation and that I am personally responsible for this fee.**

*Acknowledgement of Financial Policies:

I acknowledge that I am financially responsible for all charges whether insurance pays or not. I hereby authorize the doctor to release information necessary to process claims and to secure payment directly from the insurance carrier. We make every effort to work with our patients in the collections of their balances. **I am also aware of the office policy to forward any unpaid balances greater than 60 days on to a collections agency.** In any case collections is needed, a service fee in the amount of $30.00 will be added to my balance due. **I am also aware of the policy to charge a $25 fee for chiropractic and massage appointments that are missed without a phone call to cancel or reschedule at least 24 hours prior to my scheduled appointment time.**

*Notice of Privacy Practices:

I acknowledge that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices ("NPP") and protected health information ("PHI"), and agree to its terms. I consent to your disclosures of my information, which you deem are necessary in connection with my treatment and Risk Adjustment Activities under the Affordable Care Act (ACA) – The Practice may also disclose my PHI to an insurance company, health plan or their designated Business Associates, in response to the insurance company's or health plan's request for medical records to assess and report risk scores to the Department of Health and Human Services.

*Release of Records:

I understand that my records may be used with multiple healthcare providers who may be involved in my treatment directly and indirectly. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers.

*Minor Patients:

For **patients 17 years old and younger, a parent or guardian must accompany them for the initial exam and sign below** (exception: patients 17 years and younger declared emancipated minors) It is the parent or guardian's responsibility to bring the necessary insurance card, photo ID and make payment at the time of service.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE CONSENT. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENTS, AND BY SIGNING BELOW, I ACKNOWLEDGE MY UNDERSTANDING.

Signature of Patient or Parent/Guardian:_____ Relationship:_____

Today's Date: _____