Patient #: _____

ST. CHARLES
PAIN & WELLNESS CENTER

Please allow our staff to photocopy your driver's license and insurance details.

All information you supply is confidential. We comply with all federal privacy standards.

Please print clearly.

Today's Date:_____ **Name:**_____ **Date of Birth:** _____

Gender: _____ **Social Security Number:**___-___-____ **Address:**_____

City:_____ **State:**_____ **Zip code:**_____ **Email address:**_____

Cell Phone:_____ **Cell Carrier:**_____ **Home Phone:**_____

May we send you text message communication?: Yes No **Work Number:**_____

Occupation:_____ **Employer:**_____ **May we contact you at work?:** Y N

Preferred method of contact:_____ **Marital status:** Married Divorced Single Separated

Spouse's Name:_____ **How did you hear about us?:**_____

Race
- o American Indian
- o Alaskan Native
- o Asian
- o Black or African American
- o Native Hawaiian
- o Other
- o White
- o Decline to answer

Ethnicity
- o Hispanic or Latino
- o Not Hispanic or Latino
- o Decline to answer

Physician's Name: _____

Have you seen a chiropractor before?: Yes No

If Yes, whom and when?:

_____

HISTORY

List any allergies:	List any surgeries and their dates:	List any current medication:	List any major injuries:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Caffeine	Alcohol	Exercise	Tobacco	Pain relievers	Recreational Drug Use (optional)
○ None ○ <3 a day ○ 3-6 day ○ >3 a day	○ None ○ Occasional ○ Moderate ○ Heavy	○ Daily ○ Weekly ○ Walking ○ Running ○ Never ○ Occasionally	○ Never ○ In the past ○ Daily ○ Weekly ○ Occasionally	○ None ○ Daily ○ Weekly ○ Occasionally	○ In the past ○ Never ○ Recently ○ Occasionally

Current Condition

Primary Complaint:

_____

_____

_____

Secondary Complaint:

_____

_____

_____

Additional Complaint:

_____

_____

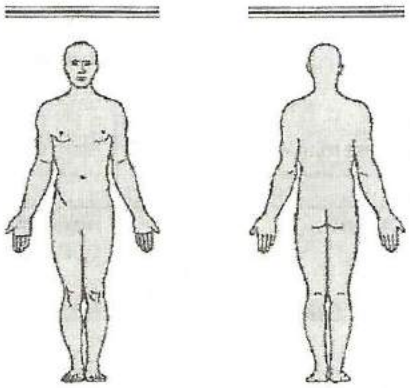
_____

How does your current condition affect:

Sitting	○ No Effect	○ Mild Effect	○ Moderate Effect	○ Severe Effect
Rising out of chair	○ No Effect	○ Mild Effect	○ Moderate Effect	○ Severe Effect
Standing	○ No Effect	○ Mild Effect	○ Moderate Effect	○ Severe Effect
Walking	○ No Effect	○ Mild Effect	○ Moderate Effect	○ Severe Effect
Lying down	○ No Effect	○ Mild Effect	○ Moderate Effect	○ Severe Effect
Bending over	○ No Effect	○ Mild Effect	○ Moderate Effect	○ Severe Effect
Driving a car	○ No Effect	○ Mild Effect	○ Moderate Effect	○ Severe Effect
Sleeping	○ No Effect	○ Mild Effect	○ Moderate Effect	○ Severe Effect

Are they a result of:

- Accident or injury
  - Work
  - Auto
  - Other
- A worsening long-term problem
- An interest in:
  - Wellness
  - Other_____



Mark your areas of complaint

(Pain=X Numbness/tingling=O)

Onset: (When did you first notice your symptoms?)

_____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication
- Over-the-counter drugs
- Homeopathic remedies
- Physical therapy
- Surgery
- Acupuncture
- Chiropractic
- Massage
- Ice
- Heat
- Other _____

How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

What else should Dr. Hertz know about your current condition?

_____

_____

_____

Review of symptoms: Chiropractic care focuses on the health of your nervous system, which controls and regulates your whole body. Please indicate whether you've **had** or **have** any of the following conditions. Leave the space blank if the condition does not apply.

Had Have	Osteoporosis	Had Have	Arthritis	Had Have	Scoliosis	Had Have	Neck Pain	Had Have	Hip Disorder
Had Have	Knee Injuries	Had Have	Foot/ankle Pain	Had Have	Shoulder Problems	Had Have	TMJ Issues	Had Have	Poor Posture
Had Have	Anxiety	Had Have	Headache	Had Have	Pins and Needles	Had Have	High Blood Pressure	Had Have	High Cholesterol
Had Have	Depression	Had Have	Dizziness	Had Have	Numbness	Had Have	Low Blood Pressure	Had Have	Poor Circulation
Had Have	Angina	Had Have	Asthma	Had Have	Emphysema	Had Have	Shortness of Breath	Had Have	Anorexia/ bulimia
Had Have	Excessive Bruising	Had Have	Apnea	Had Have	Hay Fever	Had Have	Pneumonia	Had Have	Ulcer
Had Have	Food Sensitivities	Had Have	Constipation	Had Have	Blurred Visions	Had Have	Hearing Loss	Had Have	Loss of Smell
Had Have	Heartburn	Had Have	Diarrhea	Had Have	Ringing in Ears	Had Have	Chronic Ear Infection	Had Have	Loss of Taste
Had Have	Skin Cancer	Had Have	Eczema	Had Have	Hair Loss	Had Have	Thyroid issues	Had Have	Hypoglycemia
Had Have	Psoriasis	Had Have	Stroke	Had Have	Seizures/ Epilepsy	Had Have	Immune Disorders	Had Have	Frequent Infections
Had Have	Swollen Glands	Had Have	Kidney Stones	Had Have	Diabetes	Had Have	Erectile Dysfunction	Had Have	Fainting
Had Have	Low Energy	Had Have	Infertility	Had Have	Prostate Issues	Had Have	PMS symptoms	Had Have	Low Libido
Had Have	Poor Appetite	Had Have	Sudden weight Loss/gain						
Had Have	Fatigue	Had Have	Weakness						

Acknowledgements (Please initial)

— I instruct the chiropractor to deliver the care than, in his professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation.

— I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and release on my behalf for seeking reimbursement from any involved third parties.

— I grant permission to be called or texted to confirm or reschedule an appointment and to be checked in on occasionally to track my progress.

— I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for any payment of covered or non-covered services that I receive.

— To the best of my ability, I have provided complete and truthful information.

Signature _____ Date _____

Consent to Treat Minor _____ Date _____

St. Charles Pain and Wellness Center, LLC

Jacob M. Hertz, D.C
Chiropractic Physician

302 S 14th Street
St. Charles, IL 60174
Phone (630) 513-7770
Fax (630) 513-7778

PAYMENTS AND STATEMENTS

Payment for office visits and x-rays are requested at the time of service.

Responsibility for all bills remains with the patient. If you have a financial problem, please ask to speak with the insurance administrator.

INSURANCE AND MEDICARE

Our office will bill your insurance company for all services. Our insurance administrator will confirm your insurance benefits with your insurance carrier/payer. If we are unable to confirm your benefits, you will be asked to pay for services until we can confirm those benefits.

If you have MEDICARE, we will send charges directly to MEDICARE for you. We do not accept MEDICARE assignment. If you have supplementary insurance, we will be happy to file a claim for you (we need a copy of the MEIDICARE Explanation of Benefits in order to do so).

Credit Policy

Health insurance is designed to help you meet the cost medical care. However, the responsibility of payment is yours. Your insurance contract defines the extent to which the company will reimburse you. There is no contract between the insurance payer and your doctor. It is your obligation to notify our insurance administrator of any insurance changes.

Please indicate below that you understand it is your responsibility to pay your account. If your insurance does not pay, you are responsible for the amount due.

Signature _____ Date _____/_____/_____

St. Charles Pain and Wellness Center, LLC

Consent for Purposes of Treatment, Payment and Healthcare Operations

I,_____[Name of Individual] consent to Advance Physicians ("the Practice's") use and disclosure of my Protected Health information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health information for the purposes of treatment, payment or healthcare operations of the practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of may Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician of the Practice has acted in reliance on this consent.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

ACKNOWLEDEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of St. Charles Pain and Wellness Center, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protective health Information created, received, or maintained by the Practice.

_____ _____

Date Signature

_____

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- ☐ Personally
- ☐ Mail
- ☐ Phone Follow Up
- ☐ Other _____

_____ _____

Date Signature

_____

Print Name of Physician

St. Charles Pain and Wellness Center, LLC

Name of Practice

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with the information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some ricks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase of symptoms, lack of improvement of symptoms, burns and/or scarring from electric stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractured (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With the respect to strokes, there is a rare but serious condition known as “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, incidence of hospital admission attributed to aspirin use from major GI events for the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care for all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Parent or Guardian:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____