Family Health and Wellness
CHIROPRACTIC
TRUSTED BY THE ADJUSTED

Chiropractic Case History/Patient Information

Name:_____Address:_____

City:_____ State:_____ Zip:_____ Social Security #:_____

Gender: M F Occupation:_____ Employer:_____

Race/Ethnicity:_____Birth Date:_____ Age:_____ Home Number:_____

Cell Number:_____ Office Phone:_____

Cell Carrier: _____(needed if you want to receive emails or text messages)

Email: _____ (needed if you want to receive emails or text messages)

How would you like to be contacted:☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

Marital Status: M S W D Spouse's Name:_____

Name of Emergency contact and relationship:_____

Address of contact (if not the same as yours) :_____

Phone # of contact:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case:
☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? Yes No If yes, when and describe:_____

_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how? _____

How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

How long does it last? All Day _____ Few Hours _____ Minutes _____

Are there any other conditions or symptoms that may be related to your major symptom?

Yes _____ No _____. If yes, describe: _____

Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

_____

Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

Burning _____ Stabbing _____ Shooting_____ Cramps_____ Stiffness_____ Throbbing_____

Other _____

Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____

_____. If no, what have you tried to do that has not helped? _____

_____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

On a Scale of 0-10 (10 being the worst) rate your pain_____

List any major accidents you have had other than those that might be mentioned above: _____

_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies? Yes No

If yes, describe:_____

Any past surgeries and date: _____

Any past hospitalization and date:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes _____ No _____

Uncertain _____

REVIEW OF SYSTEMS:

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously (leave blank if you've never experienced these symptoms**.

N = Now P = Previously

Headaches_____ Frequency _____
Neck Pain _____
Stiff Neck _____
Sleeping Problems _____
Back Pain _____
Nervousness _____
Tension _____
Irritability _____
Chest Pains/Tightness _____
Dizziness _____
Shoulder/Neck/Arm Pain _____
Numbness in Fingers _____
Numbness in Toes _____
High Blood Pressure _____
Difficulty Urinating _____
Weakness in Extremities _____
Breathing Problems _____
Fatigue _____
Lights Bother Eyes _____
Ears Ring _____
Broken Bones/Fractures _____
Rheumatoid Arthritis _____
Excessive Bleeding _____
Osteoarthritis _____
Pacemaker _____
Stroke _____
Ruptures _____
Eating Disorder _____
Drug Addiction _____
Gall Bladder Problems _____
Ulcers _____

Loss of Balance _____
Fainting _____
Loss of Smell _____
Loss of Taste _____
Unusual Bowel Patterns _____
Feet Cold _____
Hands Cold _____
Arthritis _____
Muscle Spasms _____
Frequent Colds _____
Fever _____
Sinus Problems _____
Diabetes _____
Indigestion Problems _____
Joint Pain/Swelling _____
Menstrual Difficulties _____
Weight Loss/Gain _____
Depression _____
Loss of Memory _____
Buzzing in Ears _____
Circulation Problems _____
Seizures/Epilepsy _____
Low Blood Pressure _____
Osteoporosis _____
Heart Disease _____
Cancer _____
Coughing Blood _____
Alchoholism _____
HIV Positive _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

Drinks/day_____

_____ Drug Use

Type _____

_____ Tobacco Use

Packs/day_____

_____ Caffeine/Coffee

Cups/day_____

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	BROTHER(S)	SISTER(S)	CHILDREN
Arthritis					
Asthma-Hay Fever					
Back Trouble					
Stroke					
Cancer					
Constipation					
Diabetes					
Disc Problem					
Emphysema					
Epilepsy					
Headaches					
Heart Disease/Failure					
HighBlood Pressure					
Insomnia					
Kidney Disease					
Liver Disease					
Migraines					
Nervousness					
Neuritis					
Neuralgia					
Pinched Nerve					
Scoliosis					
Sinus Trouble					
Stomach Trouble					
Other:					

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient or Legal Guardian _____

Date _____

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Oswestry Disability Index

Patient name _____ Date _____

Signature of Paitent or Legal Guardian _____

☐ I do not want to fill out the pain assessment form on the above date.

AREA OF PAIN? _____

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.

- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes. Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I get less than 6 hours of sleep. Because of pain, I get less than 4 hours of sleep. ☐ Because of pain, I get less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal and causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 – Social Life

- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life it normal but increases the degree of pain.
- ☐ Pain has no significant effect on my life apart from limiting my more energetic interests (i.e. sports).
- ☐ Pain has restricted my social life and I don't go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ The pain is bad but I manage journeys of over two hours.
- ☐ Pain restricts me to short, necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Section 11 – Previous Treatment

☐ Over the past three months, have you received treatment, tablets or medicines of any kind for your back or leg pain?

☐ No ☐ Yes

If yes, please state the type of treatment you have received:

_____

Kari J Skertich, DC (217) 324-5205

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the services below.

Services	Reason Medicare May Not Pay:	Estimated Cost
1) Examination (E/M) 2) Non-Spinal Manipulations (98943) 3) Therapy such as Ultrasound, electric stim, hot packs, and rehabilitation 4) Nutritional Supplements, ice packs, pillows, Biofreeze 5) Acupuncture	These are NON-COVERED items and services under Medicare when ordered and/or provided by a doctor of chiropractic.	1) $15-165 2 $35-$80 3) $45-70 4) $10-60 5)$10-25

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **services** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

□ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

□ **OPTION 2.** I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

□ **OPTION 3.** I don't want the services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Family Health and Wellness
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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ date _____
(Print Patient's Name)

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By_____
Signature of Parent/ Guardian (Circle One)

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your record will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example. The patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- The patient has the right to examine and obtain a copy of his or her own health records at the time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restriction on the use of their PHI. Our office is not obligated to agree to those restrictions.
- A Patients' written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- For your security and right to privacy, all staff has been trained in the area of patient's record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with or privacy official about ay possible violations of these polices and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

PRINTED NAME DATE

_____

Patient's Signature (or Legal Guardian if minor)

Family Health and Wellness
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INFORMED CONSENT

PATIENT NAME _____

Clinic Name: Family Health and Wellness Chiropractic

Doctor's Name: Dr Kari J Skertich

Address: _____

Phone: _____ Fax: 618-391-0202

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to, stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I am also aware of the complications that can arise from the physical modalities hereby used in the office for my care.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to, my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

I hereby authorize Dr. Kari Skertich and whomever she may designate as her assistants to administer treatment as she so deems necessary.

DATE _____

_____
Printed Name

_____
Patient's Signature

_____
Signature of Parent or Guardian (if a minor)

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Social Media Consent Form

I, _____, hereby give Family Health and Wellness Chiropractic permission to take photographs, videos, and testimonials of me for the purpose of marketing on Family Health and Wellness Chiropractic's social media sites including Facebook, YouTube, Twitter, and their clinic website.

I hereby release and discharge Family Health and Wellness Chiropractic from any and all claims arising out of use of the photos.

In signing this consent, I give authorization to use my name as printed below.

Patient's printed name _____

Signature _____ Date _____

If patient is a minor:

Parent / Legal Guardian's name _____

Signature _____ Date _____