Family Health and Wellness
CHIROPRACTIC
TRUSTED BY THE ADJUSTED

Kari J Skertich, BS, DC
Board Certified Chiropractor

Notice of Claim for Lien

Name of Patient: _____

Address: _____

_____

_____

Date of Birth: _____

Insurance Company: _____

Address: _____

_____

_____

Liable Party's Name: _____

Date of Birth: _____

Claim #: _____

Date of Accident: _____

Notice is hereby given that Family Health and Wellness Chiropractic has rendered services for the above-named patient who was injured in an accident. Family Health and Wellness Chiropractic hereby claims on any money due or owing for any claim for compensation, damages, contributions, settlement, and/or judgement from responsible party alleged to have caused the injury and/or any other person, corporation, or associated liable for the injury and/or any other person, corporation, or associate liable for the injury or obligated to compensate the injured person on the date of accident. Family Health and Wellness Chiropractic demands all money that is due to be paid to tax ID # 4704975508. Said certified lien is claimed in accordance with section 770 ILCS 23.10.

Provider Signature _____ **Date:** _____

Patient Signature _____ **Date:** _____

Dr. Kari J Skertich
101 N Old Route 66 Ste A Litchfield, IL 62056
(217) 324-5205
drkari@fhwchiro.com

AUTOMOBILE ACCIDENT QUESTIONNAIRE

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

Date of Accident:_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- ❑Car
- ❑Pickup
- ❑Van
- ❑Truck
- ❑Station Wagon
- ❑Bus
- ❑Other_____

Vehicle size:

- ❑Subcompact
- ❑Full-size
- ❑Compact
- ❑Mini
- ❑Mid-size
- ❑Light
- ❑Heavy
- ❑Other_____

Your position in the vehicle:

- ❑Driver
- ❑Passenger -------- Location-------- ❑Left ❑Middle ❑Right
- ❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

- ❑Stopped
- ❑Moving Moderately
- ❑Parked
- ❑Moving Fast
- ❑Slowing
- ❑Moving at apprx ____MPH
- ❑Moving Slowly

Why Vehicle was slowed or stopped:

- ❑Traffic Signal ❑Parking
- ❑Pedestrian ❑Traffic
- ❑Stop Sign ❑Busy Intersection

Collision Type:

- ❑Driver Side Impact
- ❑Head On Collision
- ❑Passenger Side Impact
- ❑Rear Impact
- ❑Front Impact
- ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- ❑Car ❑Pickup
- ❑Van ❑Truck
- ❑Station Wagon
- ❑Other_____

Vehicle size:

- ❑Subcompact ❑Full-size
- ❑Compact ❑Mini
- ❑Bus ❑Mid-size ❑Light
- ❑Heavy ❑Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- ❑Full daylight
- ❑Dawn
- ❑Dusk
- ❑Night

Road Conditions:

- ❑Dry
- ❑Damp
- ❑Wet
- ❑Snow covered
- ❑Ice covered
- ❑Patchy Ice/Snow

Visibility:

- ❑Excellent
- ❑Good
- ❑Fair
- ❑Poor

Visibility compromised by:

- ❑Brightness
- ❑Darkness
- ❑Rain
- ❑Snow
- ❑Fog
- ❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- ❑Totally unaware that the accident was impending
- ❑Aware that the accident was impending
- ❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)

- ❑Seat belt
- ❑Shoulder harness
- ❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?

- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

What position was YOUR headrest in?

- ❑High position
- ❑Middle position
- ❑ Low position

Position of YOUR head at time of impact?

- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?

- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left
- ❑To the left then the right
- ❑To the right
- ❑To the right, then the left

Position of Your body at time of impact?

- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?

- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left
- ❑To the left then the right
- ❑To the right
- ❑To the right, then the left
- ❑Across the vehicle
- ❑Outside the vehicle
- ❑Under the vehicle

Damage to vehicle YOU were in:

- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totalled
- ❑Not known

Citations:

- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Torso

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

❑Yes
❑No

Immediately following the accident, did you feel...?

❑Dizzy ❑Weak
❑Dazed ❑Nervous
❑Disoriented ❑Nauseated

Were you able to walk unaided?

❑Yes
❑No

Where did you go...?

❑Drove home ❑Drove to work
❑Was driven home ❑Was driven to work
❑Drove to hospital ❑Drove to school
❑Was driven to hospital ❑Was driven to school
❑Taken to hospital via ambulance

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑Low Back ❑Pelvis

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

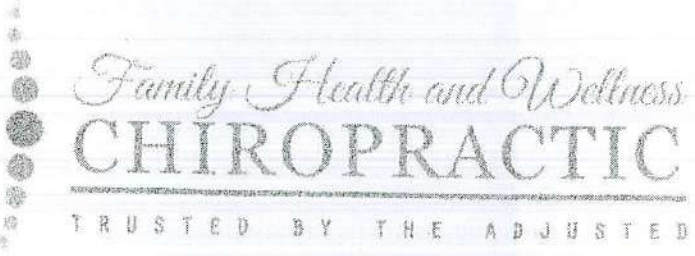
❑Low Back ❑Pelvis

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑ Low Back ❑Pelvis

Patient's Signature:_____



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 _____

Family Health and Wellness
CHIROPRACTIC
TRUSTED BY THE ADJUSTED

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)

Family Health and Wellness
CHIROPRACTIC
TRUSTED BY THE ADJUSTED

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
CHIROPRACTIC
TRUSTED BY THE ADJUSTED

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)