ProActive Spine Center

Welcome to Our Office!

Please fill out the following forms in as much detail as possible. All of your health information is confidential.

PATIENT INFORMATION

Patient Name: _____

Today's Date: _____ Date of Birth: _____

Social Security #: _____

Address: _____

City: _____ State: ___ Zip: _____

Gender: _____Height: ___ft ___in. Weight: _____

Occupation: _____

Employer/School: _____

Who May We Thank for Referring You?

_____

CONTACT INFORMATION

Home Phone: (____)_____-_____

Cell Phone: (____) _____-_____

Email Address: _____

May we contact you via (please check all applicable):

- Home Phone
- Cell Phone
- Work Phone
- Email

In case of an emergency please contact:

Name: _____

Relationship: _____

Phone Number: (_____) _____-_____

Spouse/Partner's Name: _____

Spouse/Partner's Employer: _____

PATIENT CONDITION

What is your major complaint?_____

When did this condition begin? _____

Is the condition getting progressively worse? _____

What does this condition interfere with? (work, school, recreation)_____

Other doctors seen for this condition: _____

Does this pain radiate? _____ If so, where to? _____How often? _____

Do you have numbness, tingling OR weakness? _____ Where? _____

List the severity of pain complaint: (10 is highest) #1: _____/10 #2: _____/10 #3: _____/10

What activities aggravate your condition: _____
(Heat, Ice, Lying Down, Mediation, Massage, Standing, Sitting)

What activities relieve your condition: _____
(Heat, Ice, Lying Down, Mediation, Massage, Standing, Sitting)

Have you ever had this condition before?: _____ When? _____

Do you have any allergies (food, contact, environmental)? :_____

When was your last physical? _____ Blood/Lab Work? : _____Any abnormalities?: _____

Past injuries/Surgeries: _____

List all medications you are taking: _____

_____

CIRCLE any conditions of disease you have BELOW:

ADHD, Anxiety, Autoimmune, Diabetes, Cancer, Carpal Tunnel, Fatigue, Cold Hands/Feet, Fractures, Depression, Fibromyalgia, Food Sensitivities, High Blood Pressure, Heart Disease, Vertigo, HIV/Aids, Knee Surgery, Multiple Sclerosis, Osteoporosis, Parkinson's Disease, Spinal Surgery, Stroke/TIA, Thyroid

How many hours per week do you typically sit? _____On a Computer? _____ Stand? _____

How many hours of sleep do you get a night? _____ How often do you exercise? _____

What do you hope to receive from our program? _____

ProActive Spine Center

1891 Bay Scott Circle, Suite #115 Naperville, IL 60540

HIPPA

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (HIPPA)

I, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice (the 'practice' includes Jessica J. Scherer, D.C.) has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures or my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice 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. The Practice 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 that will be used by the Practice: a) a postcard mailed to me at the address provided by me; b) telephoning my home, cell phone and/or place of employment and leaving a message on my answering machine or with the individual answering the phone; c) an educational letter series and other direct mail pieces mailed to me at the address provided by me; and d) E-mail reminders to the e-mail address that I provided.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
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 the Practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. 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 the Practice will not treat me.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ **X**_____

Name of Individual (Printed) Signature of Individual

Date Signed ____/____/____ Witness: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with 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 risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “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 dissections 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, the incidence of hospital admission attributed to aspirin use from major GI events of 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 from 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: _____

ProActive
Spine Center

Photographic, Written Word and/or Video Consent and Release Form

I, _____do hereby release to Barbian Chiropractic Center, S.C. (dba ProActive Spine Center), Jessica J. Scherer, D.C. it's agents and employees, all rights to exhibit this work in print and electronic form publicly. This includes the internet via social media sites for ProActive Spine Center via Facebook, Twitter, Website Blogs I waive any rights, claims, or interest I may have to control the use of my identity or likeness in the photographs or video and agree that any uses described herein may be made without compensation or additional consideration of me.

I do voluntarily and without compensation, hereby grant Barbian Chiropractic Center, S.C. (dba ProActive Spine Center), Jessica J. Scherer, D.C. and it's assigns the right and license to and consents to the use, reproduction, identification, and showing in any manner of the undersigned, by live telecast, picture or film, and the quoting and publishing of any and all testimonials, comments, statements and endorsements attributed to the undersigned by said entities for the purpose of supporting or promoting chiropractic care and this office. And the undersigned hereby waives any objection to such uses, reproduction, identification, showing, quotation and publication by Barbian Chiropractic Center, S.C. (dba ProActive Spine Center), Jessica J. Scherer, D.C. and its assigns.

I am only waiving my privacy right under HIPAA, insofar as the picture or accompanying endorsement imply or reveal that I am a patient or a former patient of Jessica J. Scherer, D.C. All other privacy rights under HIPAA are reserved, unless specifically released by me.

I represent that I am at least 18 years of age (or have the approval of my guardian), have read and understand the foregoing statement and am competent to execute this agreement.

FULL NAME: _____

SIGNATURE: _____DATE:_____

GUARDIAN SIGNATURE (required for minor): _____

WITNESS: _____DATE: _____

CONSENT TO TREATMENT OF MINOR CHILD

Please complete by Parent/Guardian if the patient is under 18 years old.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic diagnostic procedures (including any medically necessary x-rays) on my child by Dr. Jessica Scherer, D.C. and/or other licensed doctors of chiropractic who may be employed by or engaged in practice in Barbian Chiropractic Center, S.C (DBA, ProActive Spine Center). I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fracture, disk injuries, strokes, dislocations and sprains and that no guarantee as to results has been made to nor relied upon by me. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of treatment concerning which treatment(s) are in my best interests, based upon the facts as they are then known.

I have discussed treatment options and risks with the doctor and all of my questions have been answered satisfactorily. I, being the parent or legal guardian, hereby authorize Dr. Jessica Scherer, D.C. and whomever they may designate as assistants to administer examinations and treatment as deemed necessary to:

_____
Printed name of minor child

_____
Print name of parent or legal guardian

X_____
Signed name of parent or legal guardian

Date Signed ____/____/____

Witnessed by: _____

Female Patients Please Complete

VERIFICATION OF NON-PREGNANCY

I, _____, do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

OR

Verification of Pregnancy

- I am currently pregnant.
- How far along are you? _____

Patient's Signature: _____ Date: ___/___/___

Witnessed: _____ Date: ___/___/___