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):

- o Home Phone
- o Cell Phone
- o Work Phone
- o 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 aggrevate 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: _____

CIRCLE any conditions of disease you have BELOW:

ADHD, Anxiety, Autoimmune, Diabetes, Cancer, Carpal Tunnel, Fatigue, Cold Hands/Feet, Fractures, Depression, Fibromyalgia, Food Sensitivies, 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

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: _____

CONSENT TO CHIROPRACTIC EVALUATION AND TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic diagnostic procedures (including any medically necessary x-rays) on me by Dr. Jessica J. 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 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, acknowledge my understanding of its contents.

X_____ Date Signed ____/____/____

Signature of patient (or parent if a minor)

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 Patient 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

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

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

Witnessed: _____ Date: ___/___/___