CASE HISTORY
CONFIDENTIAL INFORMATION FORM

Patients Name _____ Date _____
Address _____ City _____ Zip Code _____
Date of Birth _____ E-Mail_____
Cell Phone # _____ Home # _____
Appointment Reminder: **Email Text Both** Cell Phone Provider: _____
Marital: **M S W D** How many children_____ Occupation _____
Employer _____ Work Phone _____
Employer Address _____ City _____ Zip Code _____
Policy Holder's Name _____ Name of Insurance Company _____
Name of Spouse _____ Occupation _____
Patient's Nearest Relative _____ Phone Number _____
Referred By _____

Are you here due to injuries suffered in a work accident? **Yes or No**
Are you here due to injuries suffered in an auto accident? **Yes or No**
Have you ever had the same or similar condition? **Yes or No** If yes, when? _____
Have you lost any days from work? **Yes or No** How many? _____
Have you ever had any operations? **Yes or No** Please list _____
Have you had any serious illnesses? **Yes or No** Please list _____
Have you ever been under chiropractic care before? **Yes or No** If yes, where? _____
Females: Are you pregnant? **Yes or No** Date your last menstrual period began _____

DO YOU:	Yes	No	Occasionally
Smoke cigarettes	_____	_____	_____
Drink alcohol	_____	_____	_____
Exercise	_____	_____	_____
Take vitamins	_____	_____	_____

DO YOU HAVE A FAMILY HISTORY OF:

Heart Disease	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Other	_____	_____	_____

Major Complaint _____

How long have you had this condition? _____

Do you know what may have caused this? _____

Have you had this or similar conditions in the past? _____

PLEASE COMPLETE THE BACK OF THIS PAGE

What activities aggravate your condition? _____

Does the condition interfere with your: Work_____ Sleep _____ Daily Routine _____
Other _____

Have you seen any other doctors regarding this condition? **(Provide names and dates)**
_____

Are your currently taking any prescription or over the counter medications? **(Please list)**
_____

Do you have a regular doctor or someone you consult about maintaining your health?
_____

Do you consider yourself a healthy person? **Yes or No**

What positive changes would better health provide for you? _____
_____

Are you interested in learning about how to prevent health problems for yourself and your family? **Yes or No**

Do you practice healthy eating habits? **Always Most of the Time Occasionally Rarely**

Are you interested in learning more about nutrition and exercise? **Yes or No**

PAYMENT OF THE FIRST VISIT IN FULL IS REQUIRED

Person responsible for payment _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date _____

Guardian or Spouse's
Signature authorizing care _____ Date _____

Information taken by _____

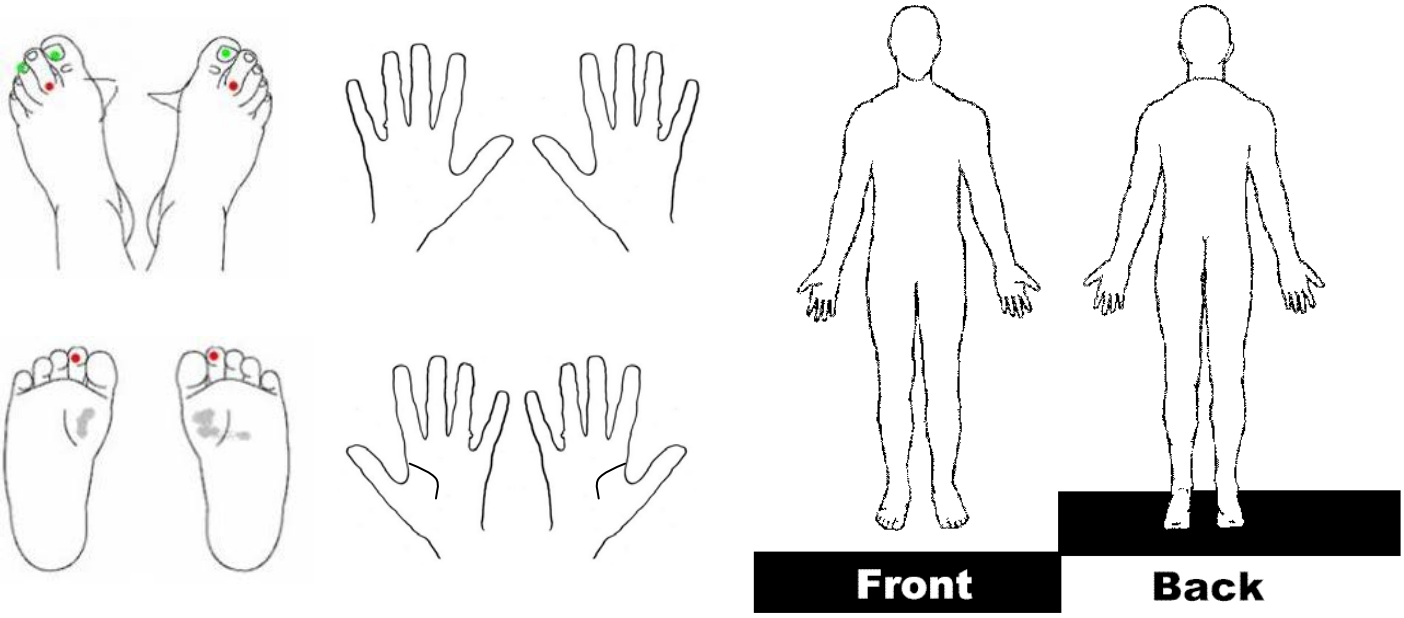
PAIN DRAWING

TELL US WHERE YOU HURT

Please read carefully:
Mark the areas on your body where you feel pain. Include all the affected areas and mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrows as far as the pain travels. Use the appropriate symbol(s) listed below.

ACHE > > > > **NUMBNESS** = = = = **PINS AND NEEDLES** 0 0 0 0

BURNING X X X X **STABBING** / / / / **THROBBING** + + + +



VISUAL ANALOG SCALE
The line below represents the intensity of your pain. Please list the region of pain and **circle** at the position on the scale which indicates how much pain you feel at this time.

1. **LOCATION OF PAIN**_____

NO PAIN MODERATE PAIN WORST PAIN IMAGINABLE

0 5 10

2. **LOCATION OF PAIN**_____

NO PAIN MODERATE PAIN WORST PAIN IMAGINABLE

0 5 10

3. **LOCATION OF PAIN**_____

NO PAIN MODERATE PAIN WORST PAIN IMAGINABLE

0 5 10

Dr. Stephen D. Perakis
Oak Lawn Chiropractic Health Center
4615 W. 103rd St.
Oak Lawn, IL 60453

Informed Consent to Chiropractic Adjustments and Care

Doctor ☐ Initials	Patient ☐ Initials	I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms, I can call the number listed above during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.
Doctor ☐ Initials	Patient ☐ Initials	I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-ray, on me by the doctor of chiropractic names above and/or in this clinic authorized by the doctor of chiropractic listed above. I have had an opportunity to discuss with the doctor of chiropractic names above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed, I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, physical therapy burns, rib injury, and strokes, Strokes are the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol.37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, as in my best interests.
Doctor ☐ Initials	Patient ☐ Initials	I have read the above consent, with the doctor, as indicated by our initials. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

To Be Completed By The Patient:

Print Patient Name_____

Patient Signature_____

Doctor's Signature_____

OSWESTRY DISABILITY INDEX 2.0

NAME_____ **DATE**_____ **SCORE**_____

PLEASE READ: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today***.

SECTION 1 - Pain Intensity
- A ☐ I have no pain at the moment.
- B ☐ The pain is very mild at the moment.
- C ☐ The pain is moderate at the moment.
- D ☐ The pain is fairly severe at the moment.
- E ☐ The pain is very severe at the moment.
- F ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (washing, dressing, etc.)
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- C ☐ It is painful to look after myself and I am slow and careful.
- D ☐ I need some help but manage most of my personal care.
- E ☐ I need help every day in most aspects of self care.
- F ☐ I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 - Lifting
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

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

SECTION 5 - Sitting
- A ☐ I can sit in any chair as long as I like.
- B ☐ I can only sit in my favorite chair as long as I like.
- C ☐ Pain prevents me from sitting more than 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

SECTION 6 - Standing
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

SECTION 7 - Sleeping
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

SECTION 8 - Sex Life (if applicable)
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

SECTION 9 - Social Life
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

SECTION 10 - Traveling
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

COMMENTS: _____

_____

_____

_____

_____

Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name_____
Employer_____
Claim/Group #_____
SS#/ID#_____

I hereby instruct and direct the _____Insurance Company to pay by check made out to and mailed directly to:

Dr. Stephen D. Perakis

4615 W. 103rd St.

Oak Lawn, IL 60453

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Oak Lawn Chiropractic Health Center

4615 W. 103rd St.

Oak Lawn, IL 60453

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Dated at _____County, this _____ day of _____ 20___

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

HIPAA Notice of Privacy Practices

Oak Lawn Chiropractic Health Center
4615 W. 103rd St.
Oak Lawn, IL 60453

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity, Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

*****SIGN ON REVERSE SIDE*****

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____