HEALTH HISTORY

Name: ______________________________ Date: ______________

List All Current Health Problems:

____

____

List Any Other Doctors Seen, Treatments And Results Obtained:

____

____

Your Current Physician(s)/Therapist(s):

____

List All Surgeries And Their Dates:

____

____

List Any Medications You Are Taking:

____

____

List Any Traumas And Their Dates:

____

____

Please Check The Conditions You Have Or Have Had:

( ) AIDS
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Chronic fatigue
( ) Depression
( ) Diabetes
( ) Epilepsy
( ) Fibromyalgia
( ) Hypoglycemia
( ) Multiple sclerosis
( ) Parkinson's disease
( ) Polio
( ) Rheumatic fever
( ) Rheumatoid arthritis
( ) Tuberculosis
( ) Venereal disease

Please Check All Present Symptoms:

CARDIOVASCULAR

( ) General swelling
( ) Swelling in legs
( ) Swelling in face
( ) Swelling around eyes
( ) Chest pain
( ) Pounding heart beat
( ) Rapid heart beat
( ) Irregular heart beat
( ) Blue or purple skin
( ) Blue or purple nail beds
( ) Cold hand/feet

VERTEBROBASILAR

( ) Double vision
( ) Loss of coordination
( ) Loss of memory
( ) Ringing in ears
( ) Heart attack
( ) High blood pressure
( ) Muscle weakness
( ) Dizziness
( ) Blurred vision
( ) Stroke
( ) Hypertension
( ) Inability to form words
( ) Burning sensations
( ) Blindness
( ) Previous head injury
( ) Previous neck injury
( ) Taking birth control pills
( ) Family history of stroke
( ) Blood vessel disease
( ) Check if you smoke
( ) Fainting
( ) Area of numbness

Musculoskeletal System

Please Check All Present Symptoms:

Head
( ) Frequent headaches
( ) Severe headaches
( ) Head feels heavy
( ) Vertigo
( ) Dizziness
( ) Light headedness
( ) Loss of taste
( ) Loss of smell
( ) Loss of hearing
( ) Loss of balance

Neck
( ) Pain in neck
( ) Pain with movement
( ) Swelling in neck
( ) Stiffness in neck
( ) Pinched nerve in neck
( ) Neck feels out of place
( ) Muscle spasms in neck
( ) Grinding sounds in neck
( ) Popping sounds in neck
( ) Limited neck movement

Mid-Back
( ) Mid-back pain
( ) Pain between shoulder blades
( ) Sharp stabbing pain
( ) Dull ache
( ) Pain from front to back
( ) Pain over kidney area
( ) Muscle spasms

Lower Back
( ) Lower back pain
( ) Lower back feels out of place
( ) Muscle spasms

Shoulders
( ) Pain in shoulders
( ) Pain across shoulders
( ) Muscle spasms
( ) Can't raise arm
( ) Above shoulder
( ) Above head

Arms & Hands
( ) Pain in upper arm
( ) Pain in forearm
( ) Pain in hands
( ) Pain in fingers
( ) Pins & needles
( ) In arms
( ) In fingers
( ) Fingers go to sleep
( ) Cold hands
( ) Swollen fingers
( ) Loss of grip strength

Hips, Legs & Feet
( ) Pain in buttocks
( ) Pain in hip
( ) Pain down leg
( ) Knee pain
( ) Leg cramps
( ) Pins & needles in legs
( ) Numbness in legs
( ) Numbness in toes
( ) Cold feet
( ) Swollen ankles
( ) Swollen feet

Health Review

Please Check All Present Symptoms:

Skin, Hair, Nails
( ) Eczema
( ) Itchy skin
( ) Rough, scaly skin
( ) Dry skin
( ) Oily skin
( ) Yellow skin
( ) Bruise easily
( ) Baldness
( ) Paper thin nails
( ) Nail bitting

Eyes
( ) Blurred vision
( ) Double vision
( ) Eye fatigue
( ) Excessive tearing
( ) Lack of tearing
( ) Light bothers eyes
( ) Excessive itching
( ) Pain in eyeball

Ears
( ) Loss of hearing
( ) Not sufficient
( ) Pain in ears
( ) Discharge from ears
( ) Vertigo
( ) Ringing in ears

Nose & Sinuses
( ) Nose bleeds
( ) Pressure over eyes
( ) Nose obstruction
( ) Frequent colds
( ) Sinusitis
( ) Loss of smell
( ) Allergies

Mouth & Throat
( ) Pain in throat
( ) Bleeding gums
( ) Abscessed teeth
( ) Dentures
( ) Difficulty swallowing

Respiratory
( ) Shortness of breath
( ) Dry cough
( ) Coughing up blood
( ) Wheezing
( ) Productive cough

Gastrointestinal
( ) Poor appetite
( ) Constant nibbling
( ) Difficulty swallowing
( ) Indigestion
( ) Nausea & vomiting
( ) Abdominal pain
( ) Change in bowel habits
( ) Diarrhea
( ) Constipation
( ) Hemorrhoids

Genitourinary
Urination is
( ) Frequent
( ) Not sufficient
The amount is
( ) High
( ) Moderate
( ) Low
( ) Frequent urination at night
( ) Intense desire to urinate
( ) Difficulty urinating
( ) Lack of control
( ) Pain with urination
( ) Dribbling
( ) Bloody urine
( ) Cloudy urine

Venereal Disease
( ) Syphilis
( ) Gonorrhea
( ) Other

Women Only
( ) painful periods
( ) spotting
( ) premenstrual symptoms
( ) irregular periods
( ) lumps in breast
( ) vaginal discharge
# of pregnancies ________
# of deliveries ________

Social History
( ) Smoking
( ) Other tobacco use
( ) Alcohol use
( ) Drink coffee or tea
Diet is
( ) Balanced
( ) Not balanced
Rest is
( ) Sufficient
( ) Not sufficient
Recreation is
( ) Sufficient
( ) Not sufficient
Family stress is
( ) Severe
( ) High
( ) Moderate
( ) Minimal
( ) None
My job stress is
( ) Severe
( ) Moderate
( ) Minimal
( ) None

( ) Nervousness
( ) Irritability
( ) Fatigue
( ) Depression
( ) Panic attacks
( ) Problems sleeping
( ) Generally feel run-down

Consent For Treatment Of Minors

I (We) being parent, guardian or custodian of ____, a minor the age of ________, do hereby authorize, request and direct Dr. ______________________________ to perform any exam, x-ray and Upper Cervical chiropractic treatment for their condition as he deems necessary.

____ ______________________________

Parent, Guardian or Custodian *Date*

Financial Office Policy

1. All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.
2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.
3. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.
4. After coverage and deductible are verified, this office may accept assignment on most polices provided the Insured/Patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to the doctor).
5. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
6. As a patient, it is your responsibility to take care of the co-payment (usually 20%) and any non-covered services on a weekly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.
7. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.
8. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.
9. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
10. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only AFTER YOUR BALANCE IS COMPLETELY CLEARED WITH THIS OFFICE.
11. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.
12. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.
13. If you change insurance companies or employers, you agree to provide this office with current information immediately.
14. This office accepts, Mastercard, Visa, Cash and Personal Checks.
15. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

______________________________ ______________________________

Patient Signature *Date*

Patient Consent For Use & Disclosure Of Protected Health Information

With my consent, Upper Cervical Health Centers Of America may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Upper Cervical Health Centers of America Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. UCHCA reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to UCHCA.

With my consent, UCHCA may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, UCHCA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Upper Cervical Health Centers of America's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Upper Cervical Health Centers Of America may decline to provide treatment to me.

________________________________ ________________________________

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

________________________________ ________________________________

Signature Date

Authorization to Pay/Release Is Granted to: Upper Cervical Health Centers Of America