Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date:_____

Name: _____ Home Phone:_____

Address:_____ City: _____ State: _____ Zip: _____

Age:_____ Birth Date: _____ Marital Status: M☐ S☐ W☐ D☐ No. of Children _____

Referred by: _____ E-mail Address:_____

Please Check Type of Payment: ☐ Cash ☐ Check ☐ MasterCard/Visa

Your Employer: _____ Occupation: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Cell Phone: _____ Your SS#: _____

Do You Have Health Insurance? ☐ Yes ☐ No Insurance Company: _____

Insurance Plan/Group#: _____ Your Work Hours: _____

Do You Have Medicare? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No

Name of Spouse or Parent: _____ Birth Date: _____

Spouse's Employer:_____ Occupation: _____

Office Phone: _____ Cell Phone: _____Spouse's SS#:_____

Describe The Major Complaints That Bring You To Our Office: _____

_____

_____

Is Your Condition Due To An Accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident? ☐ Auto ☐ Work/Job ☐ At Home ☐ Other: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. 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's Signature (For Minors): _____*Date:* _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

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

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 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

History Of Your Major Complaint

Please give us as much detail as you can regarding your MAJOR complaint that brought you to this office.

Name: _____ Date: _____

What Is The Major Complaint That Brought You To Our Office? _____

_____

How Long Have You Had This Problem/When Did It Start? _____

Is There Anything You Can Think Of That May Have Caused Your Major Complaint? _____

Is There Anything That Makes Your Symptoms WORSE? _____

Is There Anything That Makes Your Symptoms BETTER? _____

Please Explain In Your Own Words The Symptoms You Are Experiencing Pertaining To Your Major Complaint?

_____

_____

Have Your Symptoms Begun To Radiate, Travel, or Spread Yet? Do Your Symptoms Begin Somewhere and Travel Somewhere?

_____

_____

On A Scale of 0-10 (0 = No Symptoms and 10 = Unbearable) How Would You Rate Your Symptoms? (Ex: 7 / 10).

Right NOW: _____ / 10, At Its WORST: _____ / 10, At Its BEST: _____ / 10, On AVERAGE: _____ / 10

How Often Are You Experiencing Symptoms? (Ex: Daily, Weekly, Monthly) Please Explain?

_____

Is There Any Pattern That You Have Noticed With Your Symptoms? Such as Morning, Afternoon, Evening, Random, Etc.?

_____

As Time Has Gone By Are Your Symptoms Staying: The Same? Getting Better? Getting Worse? (Please Circle One)

What Have You Tried So Far To Help Improve Your Symptoms?

_____

_____

What Are Your Fears or Worries Regarding Your Major Complaint Moving Into The Future? _____

_____

What Would A Good Day Look Like For You? _____

_____

Why Do You Want To Get Better? What Would You Like To Accomplish As A Result of Care In This Office? _____

_____

_____

SF-12v2™ Health Survey

(SF-12 v2 Standard, US Version 2.0)

Identification Number
Event

To be completed by the PATIENT

Directions: *This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. If you need to change an answer, completely erase the incorrect mark and fill in the correct circle. If you are unsure about how to answer a question, please give the best answer you can.*

Today's Date (MM/DD/YY)

__ __ / __ __ / __ __

Shade circles like this: ● **Not like this:** ⊗ ✓

Mark only one answer for each question. Please do not mark outside the circles or make stray marks on the questionnaire.

	Excellent	Very Good	Good	Fair	Poor
01. In general, would you say your health is:	○	○	○	○	○

The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, not limited at all
02. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
03. Climbing several flights of stairs	○	○	○

During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
04. Accomplished less than you would like	○	○	○	○	○
05. Were limited in the kind of work or other activities	○	○	○	○	○

During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
06. Accomplished less than you would like	○	○	○	○	○
07. Did work or activities less carefully than usual	○	○	○	○	○

	Not at all	A little bit	Moderately	Quite a bit	Extremely
08. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?	○	○	○	○	○

These questions are about how you feel and how things have been with you during the <u>past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks...</u>	All of the time	Most of the time	Some of the time	A little of the time	None of the time
09. Have you felt calm and peaceful	○	○	○	○	○
10. Did you have a lot of energy	○	○	○	○	○
11. Have you felt downhearted and depressed	○	○	○	○	○
12. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, etc.)?	○	○	○	○	○

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CONFIDENTIAL PATIENT INFORMATION

This Section Is To Be Filled Out By The Doctor.

Name: _____ Date: _____ File #: _____

O:

P: B:
W:

Q:

R:

S:

Now	Worst	Best	Avg
/10	/10	/10	/10

T: C_{100-75} F_{75-50} O_{50-25} I_{25} - M A E - Course: S B W

Medical Treatment(s)/Result(s):

E / I
S / N
T / F
J / P

Other: (How Long, Frequency of Sx, #/10)

CN Deficit(s):

12 - HYPOGLOSSAL
Tongue Dev - L R N
Fasciculation - P N
Scalloping - P N
Tongue Obs:
11 - SPINAL ACCESSORY
Weak SCM - L R N
Weak Trap - L R N
10/9 - VAGUS/GLOSSOPHARYNGEAL
Hard Pal Drag - L R N
Gag Ref - Hypo Hyper N
7 - FACIAL
Eyebrows - L R N
Smile - L R N
5 - TRIGEMINAL
Light touch - L R N
Pin Prick - L R N
3 - OCCULOMOTOR
Ptosis - L R N
Pupil Cons - L R N
Pupil Size (both) - Sm Lrg Same

3, 4, 6 - TROCHLEAR/ABDUCENTS
H - Pattern
2 - OPTIC
Snellen Chart
1 - OPHTHALMIC
Smell Lt - Hypo N, Rt - Hypo N

History of accident(s):

DC History:

Diet:

Surgeries & Complication(s):

Work History:

ADL(s) limited:

Medication(s):

ANYTHING ELSE WE NEED TO KNOW TO HELP US HELP YOU?

OFFICE FINANCIAL POLICY

1. 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.

2. ESTABLISHING A NEW PATIENT FOR SPINAL CARE: The purpose of the consultation is to determine if you have a problem we can help you with, this does NOT imply free examination, x-rays, doctor's reports, and/or check-ups. Fees for service begin with examination, x-rays, doctors' reports, spinal corrections, check-ups, and re-exam's etc. Please note that our fees are updated annually and are subject to change without notice.

3. We are NOT in-network with any insurance provider. At this time our office will send a bill to your insurance company on your behalf for reimbursement for services rendered. It is your responsibility to know if you have benefits for Chiropractic services prior to your appointment if this is of concern to you. 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.

4. PAYMENT: All patients are on a cash basis. Payment is due at the time of service unless otherwise noted. This office accepts: Visa, MasterCard, Discover, Cash, and Personal Checks.

5. 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.

6. RETURNED CHECKS will incur a $35 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the returned check plus the $35 service charge to pay the balance prior to receiving services from our staff or the Doctor.

7. LATE FEES: I understand that after 30 days of non-payment a $35 dollar late fee will be added to my outstanding balance monthly until it is paid in full.

8. COLLECTION FEES: I understand that after 90 days of non-payment for services rendered that my account may be placed with a collection agency and in some instances small claims court, any additional fees incurred due to this will be added to your outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, interest, and fines. I understand that these additional fees will be my responsibility to pay.

9. PERSONAL INJURY CASES: After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured/Patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to the doctor). Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.

10. PERSONAL INJURY or GENERAL INSURANCE CASES: 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. 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. 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.

11. RESPONSIBILITY FOR PAYMENT: I understand that I am personally responsible for all charge accrued in the office. We reserve the right to charge a $63 fee for missed or no show appointments without 24 hours notice.

12. All care plans that are not completed or if you stop or suspend care, payment for ALL services provided to date is due in full. If a refund is requested it will be reimbursed less any discount given at our standard fees. All care plan visits, re-exams etc,. must be completed in the allotted time stated, i.e. 7 months, 12 months etc. There will be no refund past the allotted time frame. Please note that it is your responsibility to keep up with your appointments.

If you have questions concerning any of the above information or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor. We reserve the right to review and update these terms.

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 Boise may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to the Upper Cervical Health Centers Boise 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. UCHCB 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 UCHCB.

With my consent, UCHCB 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, UCHCB 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 Boise'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 Boise may decline to provide treatment to me.

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.

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

_____ _____

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

_____

Date

Terms Of Acceptance

When a patient seeks Chiropractic Care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic care has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Correction: An adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than a vertebral subluxation. However, if during the course of examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjustments to correct vertebral subluxations.

Individual results may vary, depending upon several factors including age of the patient, severity of the condition, severity of the spinal injury, duration of time the condition has been present, the quality of the patients lifestyle, and toxic load. Therefore, we cannot guarantee benefit due to the fact that some patients can have some level of permanent damage that is beyond our control, in spite of our best efforts. All those seeking consultation or care in this office agree not to criticize/condemn UCHCA Boise or any of its employees, associates, or partners publicly (on public forums, blogs, websites, social networks etc.) at any time or for any reason. Furthermore in doing so, I agree to pay for all costs associated with the removal of any and all criticism/condemnation or inflammatory content as noted above.

It is your responsibility to inform this office of any accidents or injuries while under care. As with any healthcare procedure, complications may arise while under chiropractic care, such as but not limited to: stiffness or soreness throughout the spine, rib fracture, disc injuries, muscle strain, cervical myelopathy, etc. Some types of spinal manipulation to the neck have been associated with injuries to the arteries in the neck, thus an association of stroke. The associated risk of stroke is said to be 1 in 2,000,000 cervical adjustments. An association does not mean cause, just like a fireman is associated with fire, it does not mean he caused the fire. A paper published by Ericksen et.al., on upper cervical chiropractic safety noted that out of a multi-doctor career total of 5,085,014 upper cervical spinal adjustments given there was not a single incidence of stroke. We are hereby informing you of these supposed risks if any. The leading cause of stroke is poor lifestyle choices such as long-term sugar abuse, and prescription drug use. Therefore the most likely reason a person may have a stroke while under Chiropractic care is due to their lifestyle choices which are beyond our control, and have nothing to do with Chiropractic. It has been shown by Herzog et.al. that the forces involved with a Chiropractic adjustment are not sufficient to cause injury to the vertebral arteries. As a corollary the forces involved in a whiplash type injury are much greater than a Chiropractic adjustment but we don't see people having strokes following whiplash injuries. Thus, if a patient sees a dentist, massage therapist, personal trainer, or Chiropractor and subsequently has a stroke it does not mean that it was caused by any of these providers, it is coincidental.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I have read and fully understand the above statements. I therefore accept care on this basis.

Patient Signature: _____ Date: _____