Patient Information Form

The following information is needed in order to better serve you. Please complete all questions.

First Name Middle Name Last Name

Name you wish to be called

Email

Address

City

State Zip Code

Home Phone

Work Phone

Cell Phone

Gender ○ Male ○ Female

Birth Date

Occupation

Employer

Marital Status Married ○ Single ○ Divorced ○

How did you hear about us? ○ Self Referral ○ Event ○ Google ○ Website ○ Other
○ Doctor- ○ Existing Patient-

Spouse's Name Phone Number Occupation

Primary reason for visiting our office

Please mark all that apply: ☐ Job Injury ☐ Auto Injury ☐ Personal injury ☐ Home injury

☐ Been Disabled- Dates: ☐ Made a report of the injury ☐ Retained an Attorney

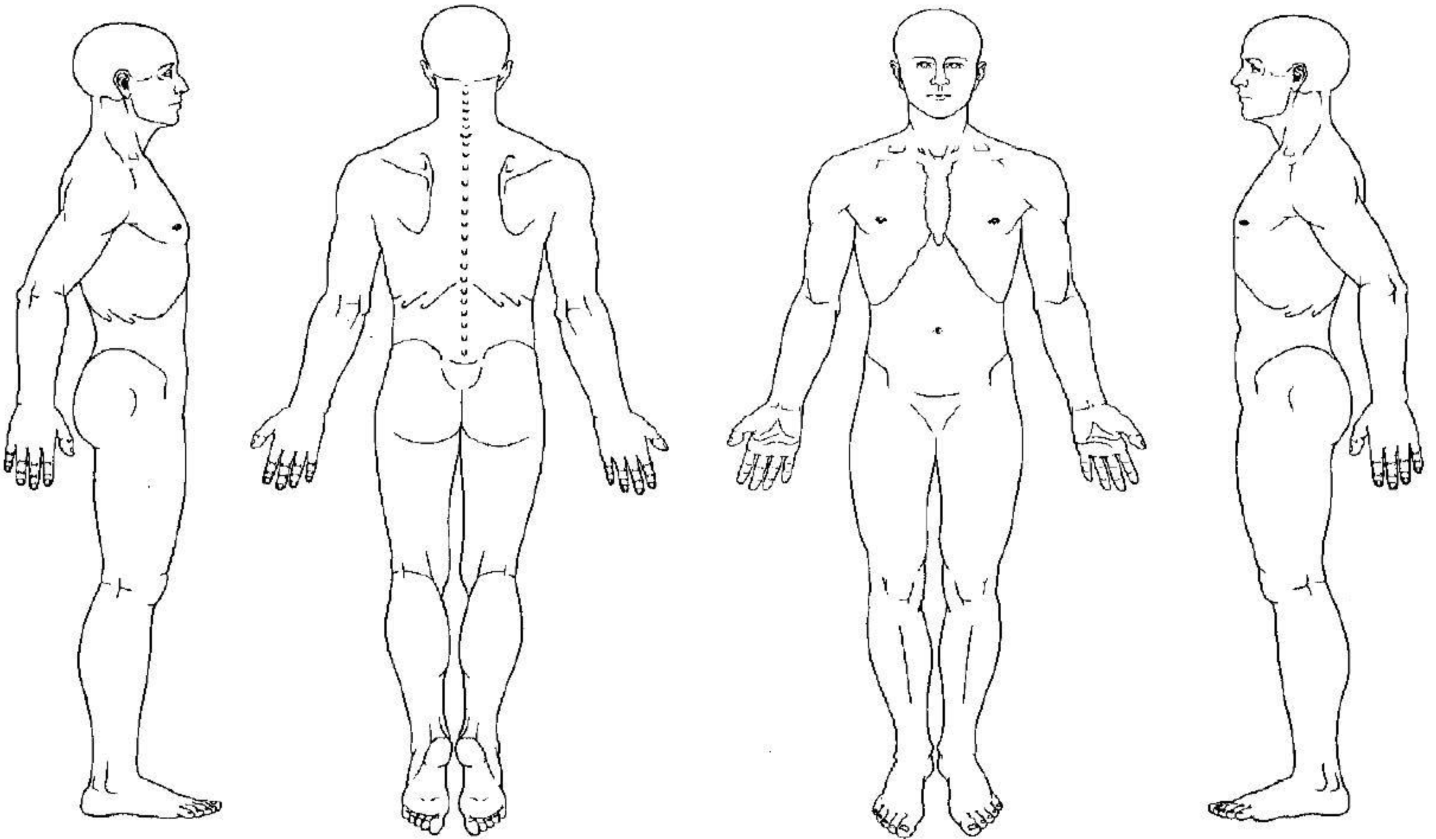
The Upper Cervical Clinic

Patient Symptom Diagram

Indicate the location and type of symptom that you are experiencing *currently*

Please mark on the diagram after you have printed this document

Numbness	= = = = =	Burning	x x x x x
Pins/Needles	o o o o o	Stabbing	/ / / / /
____________	^ ^ ^ ^ ^	Aching	a a a a a
(Please describe the symptom)			



Please indicate the region of pain (ie. shoulder, legs, etc.) and its severity, with 10 being incapacitated

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10

Region:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10

Region:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10

Region:

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10

Region:

THE UPPER CERVICAL CLINIC

Patient Condition Form

The following information is needed in order to better serve you. Please complete all questions.

Please describe your main complaint:

Please describe how and when this problem began:

Which of the following makes the symptoms better?

- ☐ Rest
- ☐ Heat
- ☐ Medication
- ☐ Stretching
- ☐ Sitting
- ☐ Ice
- ☐ Laying down
- ☐ Walking
- ☐ Standing
- ☐ Movement
- ☐ Other:

Which of the following makes the symptoms worse?

- ☐ Rest
- ☐ Heat
- ☐ Medication
- ☐ Stretching
- ☐ Sitting
- ☐ Ice
- ☐ Laying down
- ☐ Walking
- ☐ Standing
- ☐ Movement
- ☐ Other:

Describe your pain or symptoms

- ☐ Sharp
- ☐ Achy
- ☐ Burning
- ☐ Stabbing
- ☐ Pin/Needles
- ☐ Fatigue
- ☐ Dizziness
- ☐ Dull
- ☐ Other:

How often do you experience your symptoms?

- ☐ Constant (100-75%)
- ☐ Frequent (75-50%)
- ☐ Intermittent (50-25%)
- ☐ Occasional (25-1%)

Do the symptoms radiate anywhere?

- ☐ Neck
- ☐ Shoulder
- ☐ Arm
- ☐ Fingers
- ☐ Leg
- ☐ Knee
- ☐ Ankle
- ☐ Toes

How severe are the symptoms?

- ☐ Minimal
- ☐ Mild
- ☐ Moderate
- ☐ Severe

When do you experience these symptoms?

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ All the time
- ☐ Sporadically (randomly)

When was the last time you experienced this?

Is the condition: ○ Improving ○ Staying the same ○ Worsening

The Upper Cervical Clinic

Patient Health History

Please check the conditions you have or have had:

- [ ] AIDS
- [ ] Anemia
- [ ] Arthritis
- [ ] Cancer
- [ ] Chronic Fatigue
- [ ] Depression
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fibromyalgia
- [ ] High Blood Pressure
- [ ] Hypoglycemia
- [ ] Multiple Sclerosis
- [ ] Parkinson's Disease
- [ ] Polio
- [ ] Rheumatic Fever
- [ ] Rheumatoid Arthritis
- [ ] Stroke
- [ ] Tuberculosis

Please check all that Currently apply:

General History

- [ ] Trauma/Injuries
- [ ] Height changes
- [ ] Weight changes
- [ ] Fever/Chills/Sweats
- [ ] HIV positive
- [ ] Allergies
- [ ] Anemia
- [ ] Bleeding/Bruising
- [ ] Malaise/Fatigue/Weakness

Family History

- [ ] Diabetes
- [ ] Thyroid disease
- [ ] Tuberculosis
- [ ] Kidney disease
- [ ] High blood pressure
- [ ] Heart disease/Stroke
- [ ] Musculoskeletal disease
- [ ] Cancer

Endocrine System

- [ ] Heat/Cold intolerance
- [ ] Thyroid problems
- [ ] Diabetes
- [ ] Neck surgery/Irradiation
- [ ] Hormone Therapy

Eye/Ear/Nose/Throat

- [ ] Visual problems
- [ ] Eye irritation
- [ ] Pain in eyes
- [ ] Other eye problems
- [ ] Difficulty hearing/Deaf
- [ ] Ringing in ears/Dizziness
- [ ] Ear growths/Discharge
- [ ] Ear pain
- [ ] Nosebleeds
- [ ] Change in ability to smell
- [ ] Sneezing
- [ ] Nose growths/Discharge
- [ ] Nose pain
- [ ] Sinusitis
- [ ] Other nose problems
- [ ] Hoarseness
- [ ] Change in voice
- [ ] Difficulty swallowing
- [ ] Enlarged/Painful glands
- [ ] Change in ability to taste
- [ ] Dental problems
- [ ] Growths/Lesions in mouth
- [ ] Other

Gastrointestinal System

- [ ] Change in appetite
- [ ] Food intolerance
- [ ] Nausea/Vomiting
- [ ] Peptic ulcer
- [ ] Indigestion/Heartburn
- [ ] Abdominal pain
- [ ] Abdominal swelling
- [ ] Gas
- [ ] Change in stool color
- [ ] Diarrhea/Constipation
- [ ] Hernia
- [ ] Hemorrhoids
- [ ] Gallbladder problems
- [ ] Liver disease
- [ ] Pancreatitis
- [ ] Alcohol intake

Respiratory System

- [ ] Difficulty breathing
- [ ] Cough
- [ ] Blood in sputum
- [ ] Wheezing/Asthma
- [ ] Tuberculosis/Exposure
- [ ] Pneumonia/Lung infection
- [ ] Cigarette Smoking
- [ ] Other tobacco use
- [ ] Toxic fume exposure

Examiner's notes:

THE UPPER CERVICAL CLINIC

Patient Health History

Continued

Please check all that apply currently:

Cardiovascular System

- [ ] Shortness of breath
- [ ] Chest discomfort/Pain
- [ ] Palpitations
- [ ] Edema/Swelling
- [ ] Fainting
- [ ] Calf pain while walking
- [ ] High blood pressure
- [ ] Heart disease
- [ ] Cardiovascular surgeries
- [ ] Other problems

Urinary System

- [ ] Frequent urination
- [ ] Painful urination
- [ ] Changes in color
- [ ] Difficulty starting
- [ ] Difficulty holding
- [ ] Discharge
- [ ] Urinary tract infections
- [ ] Kidney disease
- [ ] Flank pain
- [ ] Pelvic pain
- [ ] Pelvic mass
- [ ] Other problems

Breasts

- [ ] Bumps/Lumps/Tenderness
- [ ] Dimples in breast
- [ ] Changes in color/size
- [ ] Nipple discharge
- [ ] Other problems

Reproductive System

- [ ] Genital lesions/Sores
- [ ] Genital mass/Growth/Pain
- [ ] Syphilis
- [ ] Prostate exam in last year
- [ ] Gonorrhea
- [ ] Change in sex drive
- [ ] Pain during sex
- [ ] Birth control
- [ ] Other sexual difficulties

Skin/Hair/Nails

- [ ] Change in skin temperature
- [ ] Change in skin texture
- [ ] Skin dryness/wetness
- [ ] Unusual skin coloration
- [ ] Rashes/Itching/Sores
- [ ] Skin growths
- [ ] Mole changes
- [ ] Skin cancer
- [ ] Skin pain
- [ ] Change in hair texture
- [ ] Change in hair growth/loss

Skin/Hair/Nails Continued

- [ ] Change in shape of fingernails
- [ ] Change in shape of toenails
- [ ] Change in color of nails
- [ ] Other problems

Neurological System

- [ ] Headaches
- [ ] Epileptic seizures
- [ ] Tics/Spasms
- [ ] Dizziness/Fainting
- [ ] Disturbances of sensation
- [ ] Unusual weakness
- [ ] Head trauma
- [ ] Stroke
- [ ] Other problems

Musculoskeletal System

- [ ] Joint stiffness
- [ ] Joint pain
- [ ] Joint swelling
- [ ] Muscle cramps
- [ ] Muscle weakness
- [ ] Muscle wasting
- [ ] Neck pain
- [ ] Mid back pain
- [ ] Low back pain
- [ ] Sacroiliac pain
- [ ] Tailbone pain
- [ ] Arm problem
- [ ] Leg problem
- [ ] Fractures/Dislocations
- [ ] Sprains/Strains
- [ ] Other injuries
- [ ] Other problems

Diet/Vitamins

- [ ] Eat meals sporadically
- [ ] Unusual appetite
- [ ] Skip breakfast
- [ ] Eat between meals
- [ ] Eat late night snack
- [ ] Eat junk food
- [ ] On special diet
- [ ] Vegetarian
- [ ] Taking supplements

Implants

- [ ] Breast implants
- [ ] Cardiac pacemaker/Etc.
- [ ] Penile implant
- [ ] Other implant

Psychological History

- [ ] Anxiety
- [ ] Depression
- [ ] Hospitalization/Therapy
- [ ] Other problems

Examiner's notes:

THE UPPER CERVICAL CLINIC

Patient Health History

Continued

Use this space to further describe any of the conditions /symptoms listed previously or any condition other than that for which you are now consulting us:

For female patients only:

Menarche (1st period) Age ____ Year ____ Days in cycle: ____

Duration: ____

Menstrual Cramping Pain

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Menstrual Flow:

○ Scant ○ Light ○ Moderate ○ Heavy

- ☐ Post menopausal bleeding
- ☐ Abnormal/Painful premenstrual fluid retention
- ☐ Other female problems
- ☐ Difficult delivery
- ☐ PMS
- ☐ Hysterectomy

Examiner's notes:

Ht:
Wt:
BP: /
HR:

Posture: L Sh. R Sh. FRS
L Hip R Hip FHP: 0.5 1.0 1.5 2.0
Head tilt L R
Head Rot. L R

ROM: C All WNL
C Flex. LL10 15 20 25 30 35 40 45 50 55 60
Ex. 10 15 20 25 30 35 40 45 50 55 60

Lat. Flex L 10 15 20 25 30 35 40 45
Lat. Flex R 10 15 20 25 30 35 40 45

Rot. L 20 25 30 35 40 45 50 55 60 65 70 75 80
Rot. R 20 25 30 35 40 45 50 55 60 65 70 75 80

Palpation: Cerv L 1 2 3 4 5 6 7 Upper Trap
R 1 2 3 4 5 6 7 Upper Trap

Thor L 1 2 3 4 5 6 7 8 9 10 11 12
R 1 2 3 4 5 6 7 8 9 10 11 12

Lumb L 1 2 3 4 5 SI
R 1 2 3 4 5 SI

TTF ( ) Fix (/)

Ortho Tests:

THE UPPER CERVICAL CLINIC

Patient Health History

Continued

Please fill out all applicable fields:

List any traumas and their dates: (especially any head and neck injuries)

List any broken bones or dislocations:

List all surgeries and their dates:

Have you ever been unconscious, if so please explain:

List any other doctors seen, treatments, and results obtained:

Patient Health History

Continued

Please fill out all applicable fields:

Please list all medications you are currently taking (prescription or OTC) and the reason for taking them:

Name of medication	Reason for taking medication

X-Ray Consent

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

Patient Consent to X-Ray

I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests and x-rays.

Females Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

_______________________________ _______________________________

Patient Signature Date

_______________________________ _______________________________

Witness Date

Consent for Treatment of Minors

I (We) being parent, guardian or custodian of ________________________________, a minor the

age of ________, do hereby authorize, request and direct the Doctors of The Upper Cervical Clinic to perform any exam,

x-ray and Upper Cervical Chiropractic care as they deem necessary.

_______________________________ _______________________________

Parent, Guardian or Custodian Signature Date

Patient Consent for Use & Disclosure of Health Information

With my consent, The Upper Cervical Clinic may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to The Upper Cervical Clinic's 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. The Upper Cervical Clinic 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 The Upper Cervical Clinic. With my consent, The Upper Cervical Clinic 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, The Upper Cervical Clinic 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 The Upper Cervical Clinic'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, The Upper Cervical Clinic may decline to provide treatment to me. I agree that a photo static copy of this agreement shall serve as the original.

Financial Office Policy

1. The Doctor will give you an estimate of the fees for service before they are performed or rendered.

2. I ________________________________ (Patient name, Parent/Guardian), agree to pay for services rendered to the below mentioned patient as the charge is incurred.

3. 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.

4. All patients are on a cash basis for care relationship with this clinic. (cash, check, credit card, exception: open MVA claims with DOI less than 1 year from today's date).

5. This office does not warrant or guarantee that your insurance will reimburse you. 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.

6. 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.

7. This office accepts Visa, Mastercard, Cash and Personal Checks (return check fee is $35).

8. If you have questions concerning this or any other matter, please speak with the Doctor prior to starting care.

Late Cancellation fee and Missed appointment fee

I understand that appointment times available with the Doctor are limited and are highly sought after for all patients in need of care. I understand a scheduled appointment is a commitment between myself and the clinic and that I am responsible to show up on time.

If I need to cancel or reschedule, **I am required to contact the Clinic (phone call or email) at least 2 hours prior to any scheduled appointment or I will be charged a late cancellation fee of $35.00** which will be paid in full before completing any future appointment.

If I failed to contact the Clinic entirely, and do not show for my appointment, a missed appointment fee of $85.00 will be charged, at the Clinic's discretion, which will be paid in full before completing any future appointment. **Showing up 15 minutes or later to an appointment**, with no prior contact to the Clinic, will also be considered a missed appointment because the subsequent scheduled patients will be arriving shortly.

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

______________________________ ______________________________

Patient Signature Date

Informed Consent For
Upper Cervical Chiropractic Care

Upper Cervical Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving Upper Cervical chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if Upper Cervical chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed) ______________________________ Relationship to patient______________________

Patient Signature (or Parent/Legal Guardian) ____________________________ Date ______________

Witness Signature (office staff)____ Date ______________