Upper Cervical
Health Centers Of America®

450 S Durkin Drive, Ste B • Springfield, IL 62704
217-698-7900 • UpperCervicalSpringfield.com

Confidential Patient Information & Health History

NAME _____ **DATE** _____

ADDRESS _____ **CITY/STATE/** _____ **ZIP**_____

HOME PHONE _____ **MOBILE PHONE** _____

WORK PHONE/S _____ **BIRTHDATE** _____

OCCUPATION _____ **EMPLOYER** _____

ADDRESS _____ **CITY/STATE** _____ **ZIP** _____

SPOUSE _____**CHILDREN (NAMES/AGES)** _____

_____

E-MAIL ADDRESS _____

WHO REFERRED YOU TO US? _____

PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION _____

_____ **LAST VISIT** _____

CURRENT MEDICAL CARE? YES/NO WHY? _____

CURRENT DRUGS/MEDICATION _____

REASON FOR CONSULTING THIS OFFICE _____

_____

PLEASE CHECK THE <u>ONE</u> CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELLBEING.

❑ I am only concerned about relief of a particular symptom.

❑ I am only concerned about relief of a particular symptom, and preventing its return.

❑ I want optimum health and wellbeing on every level available to me.

<u>WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD</u>
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature _____ Date _____

- ❖ The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.
- ❖ This interference is most commonly caused by vertebral subluxations, resulting from physical, chemical or emotional stress.
- ❖ The practice of chiropractic is based on locating and reducing the vertebral subluxation, which causes nerve system interference.

Please check any that apply

PLEASE TELL US ABOUT ANY STRESS AT YOUR BIRTH:

- ❑ **Drugs/medicine/tobacco/alcohol in pregnancy**
- ❑ **Labor chemically induced?**
- ❑ **Forceps/Vacuum Extraction/C-section**
- ❑ **Premature delivery?**
- ❑ **Vaccinations?**
- ❑ **Falls in first year of life?**
- ❑ **Any health related problems?**

Explain: _____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

- ❑ **Any falls or injuries?**
- ❑ **Allergy/Asthma or Respiratory problems?**
- ❑ **Ear infections?**
- ❑ **Digestive problems?**
- ❑ **Hyperactivity?**
- ❑ **Any other health related problems?**

Explain _____

PLEASE TELL US ABOUT ANY STRESS UP TO PRESENT:

- ❑ **Auto Accident or Injury?**
- ❑ **Work Injury?**
- ❑ **Sports Injury?**
- ❑ **Work Stress?**
- ❑ **Family/Home Stress?**
- ❑ **Prescription Drug Use?**
- ❑ **Non-Prescription Drug Use?**
- ❑ **Ever Hospitalized?**
- ❑ **Surgery?**
- ❑ **Any Major Illness?**
- ❑ **Reoccurring Illnesses?**
- ❑ **Limited Exercise?**
- ❑ **Poor Nutrition?**

Explain _____

Anything else? _____

_____

_____

Please Check The Conditions You Have Or Have Had:

Name: _____ Date: _____

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

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

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
( ) Low 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
( ) Ichy 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

Name _____ Date _____

IIIIIIIIIIIIIIIIIIIIIIIIIIIIIII Your Current Health Status IIIIIIIIIIIIIIIIIIIIIIIIIIIIIII

Physical State: Rate the following questions on a frequency scale of 1 to 5.

1 = never, 2 = rarely, 3 = occasional, 4 = regularly, 5 = constantly.

1.	Presence of physical pain (neck/back ache, sore arms/legs, etc.).	1	2	3	4	5
2.	Feeling of tension, stiffness, or lack of flexibility in your spine.	1	2	3	4	5
3.	Incidence of fatigue or low energy.	1	2	3	4	5
4.	Incidence of colds and flu.	1	2	3	4	5
5.	Incidence of headaches (any kind).	1	2	3	4	5
6.	Incidence of nausea or constipation.	1	2	3	4	5
7.	Incidence of menstrual discomfort.	1	2	3	4	5
8.	Incidence of allergies or eczema or skin rash.	1	2	3	4	5
9.	Incidence of dizziness or lightheadedness.	1	2	3	4	5
10.	Incidence of accidents or near accidents or falling or tripping.	1	2	3	4	5

Mental/Emotional State: Rate the following questions on a frequency scale of 1 to 5.

1 = never, 2 = rarely, 3 = occasional, 4 = regularly, 5 = constantly.

1.	If pain is present, how stressed are you about it?	1	2	3	4	5
2.	Presence of negative or critical feelings about yourself.	1	2	3	4	5
3.	Experience of moodiness or temper or angry outbursts.	1	2	3	4	5
4.	Experience of depression or lack of interest.	1	2	3	4	5
5.	Being overly worried about small things.	1	2	3	4	5
6.	Difficulty thinking or concentrating or indecisiveness.	1	2	3	4	5
7.	Experience of vague fears or anxiety.	1	2	3	4	5
8.	Being fidgety or restless; difficulty sitting still.	1	2	3	4	5
9.	Difficulty falling or staying asleep.	1	2	3	4	5
10.	Experience of recurring thoughts or dreams.	1	2	3	4	5

Stress Evaluation: Evaluate your stress relative to the following with,

1 = none, 2 = slight, 3 = moderate, 4 = pronounced, 5 = extensive.

1.	Family	1	2	3	4	5
2.	Significant Relationship	1	2	3	4	5
3.	Health	1	2	3	4	5
4.	Work	1	2	3	4	5
5.	School	1	2	3	4	5
6.	General well-being	1	2	3	4	5
7.	Emotional well-being	1	2	3	4	5
8.	Coping with daily problems	1	2	3	4	5

Life Enjoyment: Rate the following questions on a degree scale of 1 – 5 with,

1 = extensive, 2 = considerable, 3 = moderate, 4 = slight, 5 = not at all.

1.	Experience of relaxation or ease or wellbeing.	1	2	3	4	5
2.	Presence of positive feelings about yourself.	1	2	3	4	5
3.	Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	1	2	3	4	5
4.	Feeling of being open and aware/connected when relating to others.	1	2	3	4	5
5.	Level of confidence in your ability to deal with adversity.	1	2	3	4	5
6.	Level of compassion for, and acceptance of, others.	1	2	3	4	5
7.	Satisfaction with the level of recreation in your life.	1	2	3	4	5
8.	Incidence of feelings of joy and or happiness.	1	2	3	4	5
9.	Time devoted to things you enjoy.	1	2	3	4	5

Overall Quality of Life: Evaluate your feelings relative to the quality of your life with,

1 = delighted, 2 = pleased, 3 = mostly satisfied, 4 = mixed, 5 = mostly dissatisfied, 6 = unhappy, 7 = terrible.

1.	Your personal life.	1	2	3	4	5	6	7
2.	Your job.	1	2	3	4	5	6	7
3.	Your co-workers.	1	2	3	4	5	6	7
4.	The actual work you do.	1	2	3	4	5	6	7
5.	Your handling of problems in your life.	1	2	3	4	5	6	7
6.	What you are actually accomplishing in your life.	1	2	3	4	5	6	7
7.	Your self.	1	2	3	4	5	6	7
8.	The extent to which you adjust to changes in your life.	1	2	3	4	5	6	7
9.	Your life as a whole.	1	2	3	4	5	6	7

Any other Comments?

_____

_____

_____

_____

_____

_____

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures, and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

Name and Address of Office:
Frederick T Schurger, DC, Schurger Chiropractic, LLC dba Upper Cervical Health Centers of America
450 S Durkin Drive, Ste B, Springfield, IL 62704, 217-698-7900

_____	_____
Printed Name of Patient	Translated by
_____	_____
Signature of Patient/or Patient's representative	Date of signature
_____	_____
Witness to Patient's Signature (Office Staff)	Date of Witness Signature

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

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.

16. If your account becomes past due and is turned over for collection, there will be a collection fee of 30% of the outstanding balance added for which you will be liable for, in addition to attorney fees and court costs. **Initialed**: _____

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

_____ _____

Patient Signature *Date*

Verification Of Non-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 anyway.

_____ _____

Patient Signature *Date*

_____ _____

Witness *Date*