Name ______________________________ Date ______________

Confidential Patient Case History

Please complete this questionnaire making sure your name and the date is at the top of each page.
This confidential patient case history will become part of your permanent records.
Thank you.

Your demographic information

Last Name ____________________ First Name ____________________ M.I. ______
Street _____________________________________
____
City ___________________ State ___________
Zipcode _________________
Email _____________________________________
Home ____________________ Work ____________________
Cell ____________________ Fax ____________________
Date of Birth ___________________
Sex: F M
Social Security Number ____________________
Emergency Contact ________________________
Home Phone ____________________
Cell Phone ____________________
Occupation ______________________
Employer ____________________________
Marital Status: M S D W
Children (Ages) ____
Spouses name ____

Information about your journey to our office

Who referred you to us? ____________________
How else did you hear about us? ____________________
Were you given accurate directions to find UHI? Yes No
How did you travel here? car, bus, train, cab, bicycle, walk
Did you find parking? Yes No
Where? Circle: Street Meter Parking Garage (location) __________________________

Information about your experience with natural health care

Have you seen a chiropractor before? Yes No
If yes, who is the doctor? ____________________
Where is the doctor's office? ____________________
If yes, what was your experience; if no, what have you heard about chiropractic?
____
____
Have you used natural health care before? Yes No If yes, what kind of natural health care?
____
____

Name ________________________________ Date _______________

health problems you have that have bothered you in last 6 months

problems/complaints, please list them here:

#1 ____
#2 ____
#3 ____
#4 ____

When was the last time you experienced the problems listed above?

#1 ____
#2 ____
#3 ____
#4 ____

Do you take any medications? Yes No

What is it? How long have you taken this medication?

1. ____
2. ____
3. ____
4. ____

General Information

Your current weight _____________ Height____________

Have you lost or gained weight in the last 6 months to 1 year? Yes No

If yes, how much? ________ Did you lose it intentionally? Yes No

Your work load is (circle):

Mental work	Heavy	Moderate	Light	__________	hours/day
Physical work	Heavy	Moderate	Light	__________	hours/day
Exercise	Heavy	Moderate	Light	__________	hours/day

Your habits (circle):

Cigarette smoking	Current	Yes	No	_____ packs/day,	_____ years
	Past	Yes	No	_____ packs/day,	_____ years
Alcohol use	Beer/week	______	for	_____	years
	Wine/week	______	for	_____	years
	Liquor/week	______	for	_____	years
Caffeine use	Coffee/day	______	for	_____	years
	Tea/day	______	for	_____	years
Aspirin use	Aspirin/day	______	for	_____	years

Doctor Visits

Do you have a family physician? Yes No

What is the name of your doctor? ____________________________________

Address of this doctor: ____________________________________

Do you see this doctor each year? Yes No

When is the last time you saw this doctor? ______________________

Are you satisfied with the care you receive from this doctor? Yes No

Do you see any specialists? Yes No

What are their names and specialties?

1. ____
2. ____
3. ____
4. ____

Name ______________________________ Date ______________

Women doctor visits

Do you have a gynecologist? Yes No
What is the name of this doctor? ____
Address of this doctor: ____
Do you see this doctor each year? Yes No
When is the last time you saw this doctor? ____________________________
Are you satisfied with the care you receive from this doctor? Yes No

Family History

List anything that you know about the sickness, disease or death of the following relatives:

	Age if living	State of health	Age at death	Cause of death
Father				
Mother				
Sister(s)				
Brother(s)				
Grandmothers				
Grandfathers				

Past Diagnoses

Have you ever been diagnosed as having a disease? Yes No
What is it? ____
Have you ever been diagnosed with Cancer? Yes No
High or Low Blood Pressure? Yes No
Stroke? Yes No
Have you ever suffered from: Alcoholism? Yes No Drug Addiction? Yes No

Trauma History

Any trauma your body suffered in the past is important to helping us help you. A trauma may be obvious or non-obvious. A trauma to your body could have happened last week, ten years ago, when you were three years old or during the birth process. *Please note that body trauma is most often related to a physical event, but may also be related to a chemical event or a mental event.* This list may help you to remember (please check any that apply):

Obvious Body Trauma

- ☐ Car accident
- ☐ Bike accident
- ☐ Ski accident
- ☐ A bad sprain
- ☐ Sports injury or accident
- ☐ Roller-blading accident
- ☐ A fall
- ☐ Being struck with an object
- ☐ Something that made you bleed
- ☐ Recreational injury
- ☐ A violent birth process
- ☐ A childhood injury or accident
- ☐ A time when someone thought you were 'really hurt'
- ☐ Surgery, any type
- ☐ Injury while moving (home/work)

Non-Obvious Body Trauma

- ☐ Always sleeping in a strained position
- ☐ Sitting at a bad work-station
- ☐ Repetitive movements related to work such as mouse use, hanging head over a desk or shoulder-held phone
- ☐ Repetitive movements related to sports like tennis, golf, baseball
- ☐ Movements related to playing an instrument
- ☐ Years of small falls related to youth sports
- ☐ Repeated carrying of a heavy bag
- ☐ Long term period of being over-weight
- ☐ Pregnancy or pregnancies too close together
- ☐ Birth process with forceps or difficult birth process
- ☐ Use of a drug that caused a reaction
- ☐ Mental trauma due to death of a loved one, divorce, money, drug addiction, bankruptcy, miscarriage

Please list dates (years will suffice) of trauma to your body and include a brief description of each event.

____
____
____
____

Name ______________________________ Date ______________

PATIENT CONSENT

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to Universal Health Institute to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 312-266-9090. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____________.

X ____
Patient's Signature

X ____
Witness

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Name ______________________________ Date ______________

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

____ DATE_____________________________

SIGNATURE OF PARTICIPANT

____ DATE_____________________________

SIGNATURE OF WITNESS

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Universal Health Institute Financial Policy

We will verify your insurance benefits as a courtesy to you. Your insurance will provide a quote of benefits, not a guarantee of payment. Your insurance company retains the right to deny service payments and/or pay at a different percentage than quoted. Your insurance contract is between you, your employer, and your insurance company. We are not a party to that contract. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.____(intial).

Please note that the out-of-network benefits may apply if we are not contracted with your insurance company_____(initial).

We do not accept or bill secondary insurance carriers.If you have Medicare and your have supplemental insurance, Medicare will send the claim to your secondary insurance on your behalf. _____(initial).

If referrals or prescriptions are required by your insurance company, you are solely responsible for obtaining and keeping track of them.____(initial).

If your insurance company has not paid a claim within ninety (90) days of submission, you accept full responsibility for payment in full of any outstanding balance ____(initial).

Your copayment, coinsurance and deductible must be paid at the time of service.____ (initial).

All services must be paid in full if you are satisfing a deductible set by your insurance copay. Any credits to your account will be applied to future visits____(initial).

If you discontinue care for any reason other than discharge by the doctor, all patient balances become immediately due and payable in full by you and you authorize us to use your credit card to collect full payment.____(initial).

In the case that an account becomes delinquent (90 days past due) and we are unable to charge your credit card for the balance due, your account will be turned over to a third-party collection agency. If this occurs, our staff will no longer handle the account and all correspondence and phone calls will be directed to our agency Keynote Consulting.____(initial).

All patients are required to maintain a valid credit card number on file with us. If you choose not to provide this information, we will not bill your insurance and you must pay cash for all service provided to you_____(initial).

Cancellations:
Scheduled visits are available for all services at UHI. If you are unable to make your appointment, 24 hour notice must be given. If you make an appointment on another patient's behalf, you assume all financial responsibility for that appointment in the event of a cancellation or misssed appointment. Any missed appointment carry a charge of $50.00 (except for chiropractic adjustments). This fee are not covered by insurance and must be paid before scheduling another appointment.

This financial policy supercedes any and all previous financial policies, contracts, and agreements issued by Universal Health Institute.____(initial).

Card #____Expiration Date_________________

CVV Code (3 digit number on the back of your card)____________

Printed Name as Appears on Card:____

Signature:____Date:________________________

Witness:____Date:________________________

X-ray Assignment Agreement and Consent

I understand that my doctor is submitting my x-rays to Spinal Imaging, Inc. for second opinion radiological evaluation and analysis by a specialist. I also understand that the fee for such services will be submitted to my insurance company, healthcare carrier, attorney or worker's compensation carrier for payment. If I am paid directly by an insurance carrier or through legal a legal settlement, I will be responsible for the amount paid. If Spinal imaging, Inc. does not receive a lien, or if Spinal Imaging, Inc. does not receive a reply to a case status information request from my attorney, I will be billed for the amount of service. Once Spinal Imaging, Inc. receives a reply from the attorney, I will stop being billed.

I also give my consent to Spinal Imaging, Inc's use and disclosure of the Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance on this consent. I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy of Spinal Imaging, Inc, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.
My signature authorizes the release of medical information and also authorizes the assignment of benefits to:

Spinal Imaging, Inc.
5 Norfolk Avenue
P.O. Box 1200
South Easton, MA 02375

In the event my insurance company or attorney sends payment of services to me, I agree to promptly remit such payment to Spinal Imaging, Inc.

______________________ ______________________________

Date **Patient Signature**

____

Print Name