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 ______________

In this box, describe your *main problem* only

If we could help you with **one** health **problem**, what would it be? Write you main problem/complaint here: ____

Answer the 10 most important questions about your problem here:

1. How many days out of the week or month do you find yourself suffering from this problem? Be specific, please. Circle one, if it applies to your problem:
   Every day. Every other day. Several (2,3,4,5,6) days per week/month.
2. How long will it last on a bad day? ______________________________
3. How long have you been suffering with this problem/complaint? (Since what year/month) Be specific, please. ______________________________
4. Have you had this or a similar condition in the past? Yes No
   If Yes, describe it here______________________________
   ____
5. Has the problem been getting worse over time? Yes No
6. When the problem is at its worst, exactly what does it feel like?
   ____
   ____
7. On a scale of 1-10, with 10 being the worst, how do you rate this pain right now?
   Rate the pain right now: 1 2 3 4 5 6 7 8 9 10
8. On a scale of 1-10, with 10 being the worst, how do you rate this pain in the last week? Rate the pain in the last week: 1 2 3 4 5 6 7 8 9 10
9. What do you do that makes this problem worse?
   ____
   ____
10. Many people tell us that their condition makes them feel older than they are. Have you experienced this? Yes No How does it make you feel? ______________________________

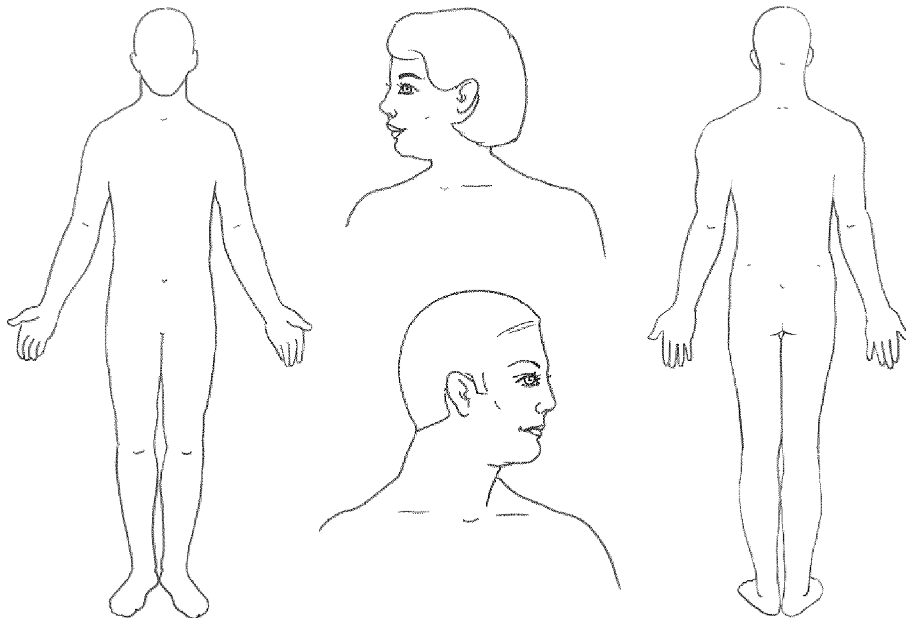
Mark the areas of your symptoms on the figures to the right. Use the following symbols to describe them:

Aches + + + + +

Numbness * * * *

Pins/Needles - - - - -

Stabbing / / / / /



Describe what *caused* your problem.

Do think that a specific accident/injury/trauma caused this problem? Yes No
If yes, what was the event? ______________________________
____

Have you had any falls or accidents in the past that may have caused injury to your neck and spine, even as a child? Yes No ______________________________

Name ______________________________ Date ______________

In this box, describe how you have tried to manage this problem

Since the time you began suffering from this problem, what, if anything, have you tried as a remedy or cure that did not work? Please circle all that apply to your main problem:

Ice, heat, rest, over-the-counter drugs, physical therapy, exercise, stretching, massage, prescription drugs, doctor advice, ignoring it, waiting, change in diet, change in habits, staying away from activities, prayer, meditation, wishing, concentrating, acupuncture, changing activities, limiting activities, sleep, nutrition.

Anything else that you have tried to do to help your problem? ______________________________

Anything that has given you relief? Yes No If yes, what was it that gave you the most relief?

____

Even if you have experienced temporary relief, has anything you have tried thus far fixed your problem yet? Yes No What was it? ____

In this box, describe how this problem is affecting you

Answer the following 10 important questions about your problem:

1. What activity does this problem prevent you from doing either partially or totally, that you would really like to be doing again if you didn't have this condition? ____________________________

   ____
2. How does this problem prevent you from doing that? ____________________________________

   ____
3. What areas of your life is it most affecting?

   Circle any that apply: My Work. My Hobbies. My Social Activities. My Sports.
   My Ability to Rest. My Family Life. My Attitude. My Financial Plan.
   My Personal Life. My Productivity. My Appetite. My interest in Others.
   My Personal Hygiene. My enthusiasm. My Ability to Concentrate. My mental state.
4. How else is it affecting you? ____
5. Has this problem affected your sleep patterns?

   Trouble falling asleep because you are uncomfortable? Yes No
   Not enough restful sleep? Yes No
   Awakening in the middle of the night? Yes No
   Waking you earlier than you would normally awake? Yes No
6. Have you become discouraged about this? Yes No
7. If you are not discouraged, does it concern you that your problem persists? Yes No

   Why does it concern you? ____

   ____
8. Are you concerned that it will not go away or get worse in the future? Yes No
9. How often are you able to keep a positive attitude?

   Circle: Most of the time Some of the time Not very often Hardly at all
10. If you don't get this problem taken care of where do you think you will be in 5 years?

    ____

    ____

Are you ready to take care of this problem?

Taking into consideration what you have described so far, so you feel you need to change the way you have been dealing with this problem? Yes No

On a scale of 1 – 10, ten being the highest, how would you rate your commitment to getting rid of this problem? 1 2 3 4 5 6 7 8 9 10

Is there anything preventing you from getting this problem taken care of? Please specify your concerns: ____

Name ______________________________ Date ______________

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

If you have any other 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.

____

____

____

____

QUADRUPLE VISUAL ANALOGUE SCALE

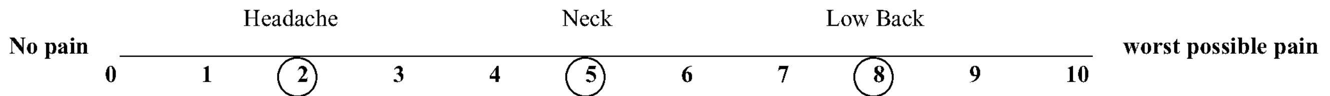
Patient Name ______________________________ Date ____________________

Please read carefully:

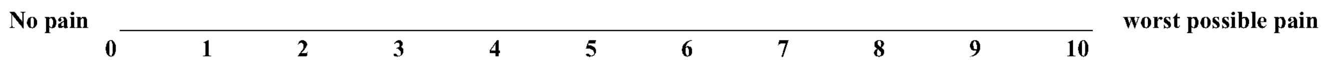
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

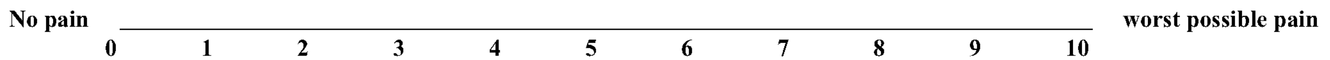
Example:



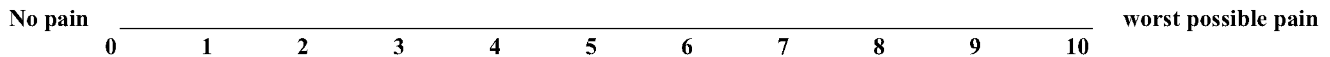
1 – What is your pain RIGHT NOW?



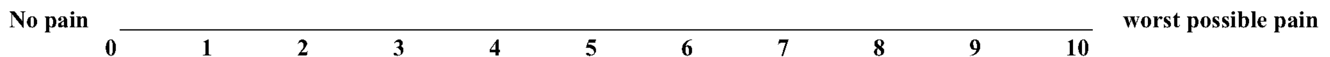
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

HEADACHE DISABILITY INDEX

Patient Name ____ Date ___________________________

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
_____	______	_____	E1.	Because of my headaches I feel handicapped.
_____	______	_____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
_____	______	_____	E3.	No one understands the effect my headaches have on my life.
_____	______	_____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	______	_____	E5.	My headaches make me angry.
_____	______	_____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
_____	______	_____	F7.	Because of my headaches I am less likely to socialize.
_____	______	_____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
_____	______	_____	E9.	My headaches are so bad that I feel that I am going to go insane.
_____	______	_____	E10.	My outlook on the world is affected by my headaches.
_____	______	_____	E11.	I am afraid to go outside when I feel that a headaches is starting.
_____	______	_____	E12.	I feel desperate because of my headaches.
_____	______	_____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
_____	______	_____	E14.	My headaches place stress on my relationships with family or friends.
_____	______	_____	F15.	I avoid being around people when I have a headache.
_____	______	_____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
_____	______	_____	F17.	I am unable to think clearly because of my headaches.
_____	______	_____	F18.	I get tense (eg, muscle tension) because of my headaches.
_____	______	_____	F19.	I do not enjoy social gatherings because of my headaches.
_____	______	_____	E20.	I feel irritable because of my headaches.
_____	______	_____	F21.	I avoid traveling because of my headaches.
_____	______	_____	E22.	My headaches make me feel confused.
_____	______	_____	E23.	My headaches make me feel frustrated.
_____	______	_____	F24.	I find it difficult to read because of my headaches.
_____	______	_____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS:____

____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.

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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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

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:________________________