



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: _____ Email Address: _____

Please Check Type of Payment: Cash Check Credit Card/Debit (Visa/Mastercard)

Employer: _____ Occupation: _____ Yrs on Job: _____

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

Office Phone: _____ Cell Phone: _____ SS# _____

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

Insurance Plan/Group#: _____ Medicare/Medicaid (circle) Yes No

Name of Spouse or Parent: _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

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

Describe The Major Complaint/Concern: _____

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 or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ **Date:** _____

Guardian's Signature: _____ **Date:** _____

Notice to 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.



FINANCIAL OFFICE POLICY

With my consent, Agape Upper Cervical Health Center, Inc., may use and disclose protected health information (PHI) to carry out treatment, payment, and healthcare options (TPO). Please refer to Agape Upper Cervical Health Center, Inc. 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. Agape UCHC 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 Agape UCHC.

With my consent, Agape UCHC, may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assists the practice of caring out TPO, such as appointment reminders, insurance items or any call pertaining to my chiropractic care.

With my consent, Agape UCHC 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 Agape Upper Cervical Health Center, Inc.'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, Agape Upper Cervical Health Center, Inc. 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:

Agape Upper Cervical Health Center, Inc.
1122 Cambridge Square
Suite A
Alpharetta, GA 30009



INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Charmaine Herman, Doctor of Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian's Signature _____ Date _____

Witness Signature _____ Date _____



How did you hear about our office? _____

PATIENT'S HEALTH HISTORY

Medical Conditions: Check all boxes that apply to you

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |

Surgeries: Check all boxes that apply to you

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gastro-intestinal | <input type="checkbox"/> Uro-genital | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Other _____ | |

Allergies: Check all boxes that apply to you

- | | | | |
|---|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Mold | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Animal |
| <input type="checkbox"/> Chemical _____ | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Glutens | <input type="checkbox"/> Other _____ |

Social History: Check all boxes that apply to you

- | | | | |
|----------------|---|--|-----------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Water: | <input type="checkbox"/> <64 oz/day | <input type="checkbox"/> >64 oz/day | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Sleep: | <input type="checkbox"/> <8 hours/night | <input type="checkbox"/> >=8 hours/night | <input type="checkbox"/> Insomnia |
| Other _____ | | | |

Family History: Check all boxes that apply to you

- | | | | | |
|---------------|---------------------------------|----------------------------------|--------------------------------------|--------------------------------------|
| Arthritis: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Other _____ |
| Cancer: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Other _____ |
| Diabetes: | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Other _____ |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Other _____ |
| Hypertension | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Other _____ |
| Stroke | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Other _____ |
| Thyroid | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Other _____ |

Occupational Activities: Check one (1) box that best describes your occupation/job

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business Owner | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer Operator |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Construction | <input type="checkbox"/> Health Care |



- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Food Service Industry | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper |
| <input type="checkbox"/> Student | <input type="checkbox"/> Educator/Teacher | <input type="checkbox"/> Engineering | <input type="checkbox"/> Other _____ |

Review of Systems: Please check all boxes that apply if you have/had **Past, Present or No** issues with any of the following conditions

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat	Past	Present	No
Jaw Pain				Eyes	Past	Present	No	Difficulty Swallowing			
Irregular Heartbeat				Glaucoma				Dizziness			
Swelling of legs				Double Vision				Hearing Loss			
				Blurred Vision				Sore Throat			
Genitourinary	Past	Present	No					Nosebleeds			
Kidney Disease				Psychiatric	Past	Present	No	Bleeding Gums			
Burning Urination								Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal	Past	Present	No
Kidney Stones				Stress							
Lower Side Pain								Gall Bladder Problems			
				Endocrine	Past	Present	No	Bowel Problems			
Neurologic	Past	Present	No					Constipation			
				Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic	Past	Present	No				
Pinched Nerves								Musculoskeletal	Past	Present	No
Parkinson's				Hepatitis							
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Metabolism	Past	Present	No	Bleeding				Muscle Weakness			
				Fever, Chills				Osteoporosis			
Weight Loss/Gain				Sweating				Broken Bones			
Low Energy Level				Varicose Vein				Joints Replaced			
Difficulty Sleeping								Neck Pain			
								Low Back Pain			
								Upper Back Pain			



Please list all current medications being taken:

Are You Pregnant? Yes No Not Sure Not Applicable

Present Chief Complaint: Please use the key below to indicate/draw on the body diagram below where you are experiencing the following symptoms

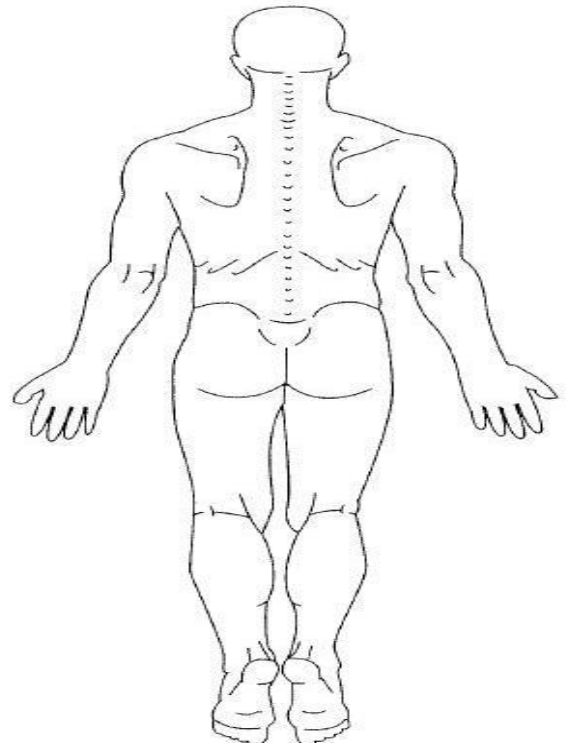
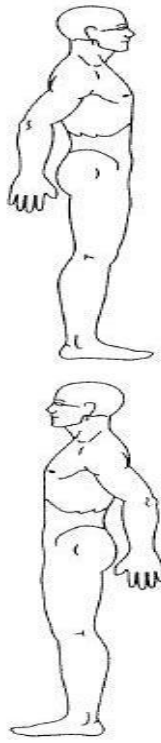
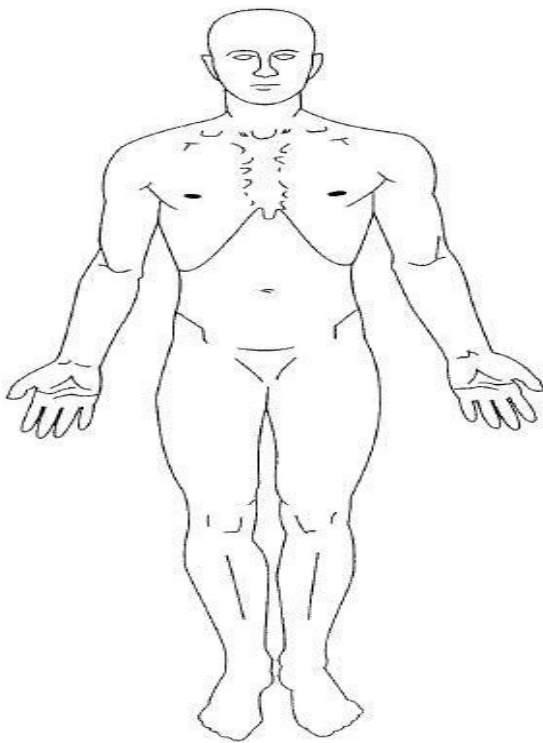
N=Numbness

B=Burning

S=Sharp

T=Tingling

A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How are your symptoms changing? Getting Better Not Changing Getting Worse

Does this complaint travel to any other parts of your body? Yes No

If Yes, where? _____

Does anything improve your pain? Yes No **If Yes, please list:** _____



Does anything increase your pain? Yes No **If Yes, please list:** _____
When did your symptoms begin? _____

How did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work Related Accident
 Other _____

Have you started any new activities like sports, hobbies, job, or workouts recently? Yes No
If Yes, please list: _____

How often do you experience your symptoms?
 Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Have you experienced these symptoms before? Yes No **If Yes, explain** _____

What words best describe your symptoms?
 Sharp Ache Numb Shooting
 Burning Tingling Throbbing Dull
 Other _____

Does this complaint prevent you from performing any daily activities like getting dressed, driving, working, etc.? Yes No **If Yes, explain** _____

Does this complaint prevent you from performing any other activities like hobbies, reading, exercise, etc.? Yes No **If Yes, explain** _____

Is there anything else you would like the doctor to know regarding your complaint? Yes No
If Yes, explain _____

Patient's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____