Agape Upper Cervical
Health Center, Inc.

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 me, arrangements must be made in advance before seeing the doctor.

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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.

I also give Dr. Charmaine Herman permission to use my condition and treatment for educational purposes through teaching or in research articles and publications. I understand that all identifying information (name, address, phone number, physical description, etc) will be withheld from disclosure.

Patient/Guardian's Signature___________________________________ Date _____________

Witness Signature ____ Date_____________

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How did you hear about our office? ____

PATIENT'S HEALTH HISTORY

<u>Medical Conditions</u>: Check all boxes that apply to you

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _______________	☐ Fibromyalgia	☐ Asthma	☐ Osteoporosis

<u>Surgeries</u>: Check all boxes that apply to you

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Breast Augmentation	☐ Tonsillectomy	☐ Other _______________	

<u>Allergies</u>: Check all boxes that apply to you

☐ Mold	☐ Seasonal	☐ Milk or Lactose	☐ Animal
☐ Chemical ____________	☐ Sulfites	☐ Wheat/Glutens	☐ Other ______________

<u>Social History</u>: Check all boxes that apply to you

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Drink Water:	☐<64 oz/day	☐>64 oz/day	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Sleep:	☐<8 hours/night	☐ >=8 hours/night	☐ Insomnia

Other _________________

<u>Family History</u>: Check all boxes that apply to you

Arthritis:	☐ Parent	☐ Sibling	☐ Grandparent	☐ Other ________________
Cancer:	☐ Parent	☐ Sibling	☐ Grandparent	☐ Other ________________
Diabetes:	☐ Parent	☐ Sibling	☐ Grandparent	☐ Other ________________
Heart Disease	☐ Parent	☐ Sibling	☐ Grandparent	☐ Other ________________
Hypertension	☐ Parent	☐ Sibling	☐ Grandparent	☐ Other ________________
Stroke	☐ Parent	☐ Sibling	☐ Grandparent	☐ Other ________________
Thyroid	☐ Parent	☐ Sibling	☐ Grandparent	☐ Other ________________

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

☐Administration	☐ Business Owner	☐ Clerical/Secretary	☐Computer Operator
☐Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services

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☐ Heavy Manual Labor ☐ Light Manual Labor ☐ Executive/Legal ☐ Housekeeper
☐ Student ☐ Educator/Teacher ☐ Engineering ☐ Other ________

<u>Review of Systems</u>: 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**				
Irregular Heartbeat								Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary	**Past**	**Present**	**No**	Blurred Vision				Sore Throat			
								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			

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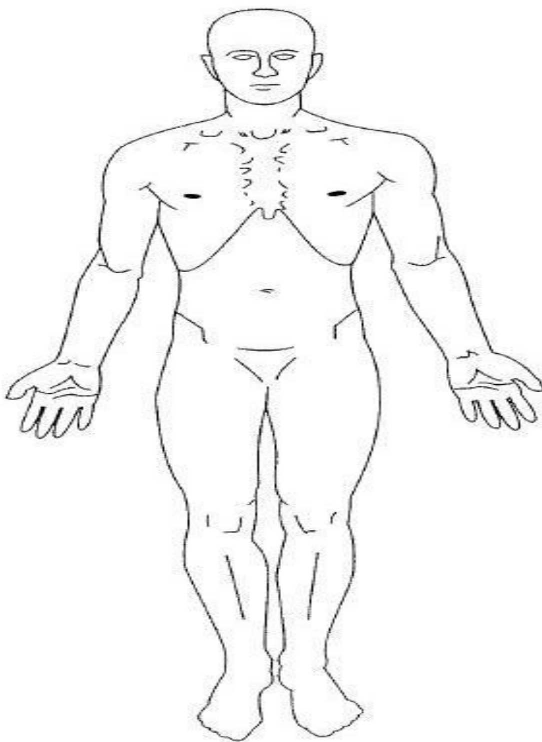
Please list all current medications being taken:

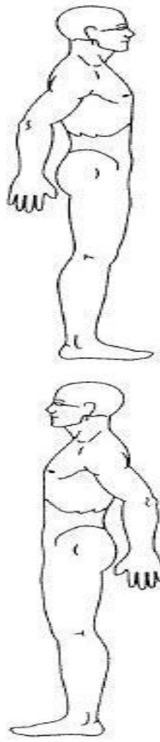
____
____
____
____

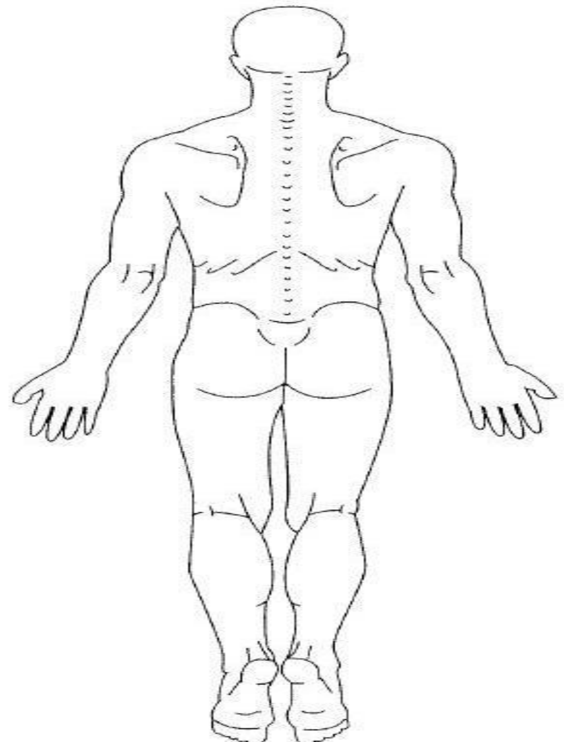
Are You Pregnant? □Yes □No □Not Sure □Not Applicable

<u>Present Chief Complaint:</u> 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:

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

<u>Past week:</u> 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:**________________________

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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	□ Frequently	□ Occasionally	□ Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(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 __________________	□Unbalanced	□Tinnitus	□Foggy

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**:______________________

Which of the following best describes you?

Please select one answer.

- ❍ Asian or Pacific Islander
- ❍ Black or African American
- ❍ Hispanic or Latino
- ❍ Native American or Alaskan Native
- ❍ White or Caucasian
- ❍ Multiracial or Biracial
- ❍ A race/ethnicity not listed here