Intake Form

Upper Cervical Spine Centers of Michigan
PATIENT APPLICATION FORM

First Name: ____

Preferred Name: ____

Date of Birth: ______________ Gender: ________________ Sex: _____________________

Height: ___________ Weight: ___________

Marital Status: Single Married Separated Divorced Widowed

Street Address: ____

Apt./Unit #: ___________________ City: ____

State: ______________________________ Zip Code: _____________________________

Mobile/Home Phone: ___________________ Work Phone: __________________________

Email: ____

Occupation: ____________________Employer: __________________________________

Work Address: ____

Apt./Unit #: __________________ City: ____

State: _________________________________ Zip Code: __________________________

Primary Care Physician: ____

Spouse's Name: ____

Number of Children: ________________

Emergency Contact Name: __________________________Phone: ____________________

Emergency Contact Relationship: ____

Who may we thank for referring you to the office? ____________________________________

New Policy

Our office is out of network with all insurance providers. A superbill (detailed receipt) can be provided to you for out-of-network reimbursement, depending on your policy. Our billing department can contact your insurance provider to check your out-of-network benefits after your consultation.

We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Health Issue

1.
2.
3.
4.
5.

Date Conditions Started- Reference the numbers in question above

1.
2.
3.
4.
5.

Frequency (ex: Constant, On and Off, 1 x week, 1 x month, Daily)

Severity - Scale of 1-10 (1 is no pain and 10 is you need to go the hospital)

Are these conditions getting worse? ☐ Yes ☐ No

Is this: ☐ Constant ☐ Frequent ☐ Occasional ☐ Activity Related

How would you describe your pain/discomfort (circle all that apply)

Dull Achy Throbbing Stiff Sharp Stabbing Shooting Intense Burning

Constricting Other (please describe)

If circled, please describe:

Does your condition interfere with: (circle all that apply) Work Sleep Hobbies

Daily Routine

please describe:

What activities aggravate your symptoms?

☐ Coughing ☐ Sneezing ☐ Bearing Down ☐ Lifting ☐ Bending ☐ Pushing ☐ Pulling
☐ Driving ☐ Sitting ☐ Walking ☐ Running ☐ Standing ☐ Laying Down ☐ Movement

Is there anything, which has relieved your symptoms?

☐ Yes ☐ No ☐ Ice ☐ Heat ☐ Massage ☐ Resting ☐ Exercise ☐ Sitting ☐ Standing
☐ Bracing/Taping ☐ Stretching ☐ Popping Joints ☐ Laying ☐ Other

Purpose of This Visit (continued)

Does your pain radiate from primary area? ☐ Yes ☐ No
If yes, where?

Do you experience numbness and tingling anywhere? ☐ Yes ☐ No
If yes, where?

Who have you seen for this? What did they do?

How did you respond?

Experience with Chiropractic

Have you seen a chiropractor before? ☐ Yes ☐ No
If yes, who and when?

Reason for visits? How did you respond?

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

Did you know posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor posture habits? ☐ Yes ☐ No
Please Explain:

Are you aware of poor posture habits in your spouse or children? ☐ Yes ☐ No
Please Explain:

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck?
☐ Yes ☐ No

Health Lifestyle

Do you exercise? ☐ Yes ☐ No
If yes, how often?

What activities?

☐ Running/Walking ☐ Weight Training ☐ Cycling ☐ Yoga/Pilates ☐ Other

Do you smoke? ☐ Yes ☐ No
If yes, how often?

Do you drink alcohol? ☐ Yes ☐ No
If yes, how often?

Do you drink coffee? ☐ Yes ☐ No
If yes, how often?

Do you take any supplements? (vitamins, minerals, herbs) ☐ Yes ☐ No
If yes, how often?

Health Conditions:

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse effects on your overall health. The most common and detrimental postural distortion is called forward head syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health conditions you may be experiencing, now or in the past.

CERVICAL SPINE (NECK) Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience:

☐ Neck Pain ☐ Headaches/Migraines ☐ Allergies/Hay Fever ☐ Skin Issues-Acne/dryness
☐ Recurrent colds/flu ☐ Pain into shoulders/arms/hands ☐ Thyroid Conditions ☐ Sinusitis
☐ Hearing Disturbances ☐ Depression/anxiety ☐ Weakness in grip
☐ Numbness/tingling in arms/hands ☐ TMJ/Pain/Clicking ☐ Dizziness
☐ Visual Disturbances ☐ Difficulty focusing/ADHD ☐ Coldness/sweating in hands
☐ General Fatigue ☐ Insomnia ☐ Low Metabolism ☐ Difficulty losing weight
☐ Brain Fog/Difficulty focusing

THORACIC SPINE (UPPER BACK) Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience:

☐ Heart palpitation ☐ Tachycardia ☐ Heart murmurs ☐ Shortness of breath
☐ Recurrent lung infections/bronchitis ☐ Asthma/wheezing ☐ Heart attack/angina
☐ Pain on deep inhalation/exhalation

THORACIC SPINE (MID BACK) Postural distortions from subluxations (resulting from ForwardHead Syndrome)in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience:

☐ Mid back pain ☐ Nausea ☐ Pain into ribs/chest ☐ Acid reflux ☐ Ulcers/gastritis

☐ Indigestion/heartburn ☐ Hypoglycemia

☐ Tired/irritable after eating or when you haven't eaten

LUMBAR SPINE (LOW BACK)Postural distortions from subluxations in the low back (resulting from ForwardHead Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience:

☐ Pain into hips/legs/feet ☐ Numbness/tingling into your legs/feet

☐ Coldness in your legs/feet ☐ Muscle cramps in your legs/feet

☐ Constipation/diarrhea/gassiness/bloating

☐ Low back pain ☐ Weakness/injuries in your hips/knees/ankles

☐ Recurrent Bladder Infection ☐ Frequent/difficulty urinating

☐ Menstrual irregularities/cramping (females) ☐ Sexual Dysfunction

MEDICAL HISTORY

Do you or any one in your family been diagnosed with any of the following:

☐ Diabetes ☐ Rheumatic Fever ☐ High Blood Pressure ☐ Kidney Disease ☐ Liver Disease

☐ Broken Bones/Fractures ☐ Pneumonia ☐ Whooping Cough ☐ Thyroid ☐ Arthritis

☐ Gout ☐ Varicose Veins ☐ Circulatory Problems ☐ Heart Disease ☐ Seizures

☐ Metal Implants ☐ Appendectomy ☐ Polio ☐ Chicken Pox ☐ Small Pox ☐ Epilepsy

☐ Prostate ☐ Neurological Problems ☐ Stroke ☐ Cancer ☐ Migraine

☐ Infectious Disease ☐ Tonsillectomy ☐ Tuberculosis ☐ Mumps ☐ Influenza

☐ Difficulty Urinating ☐ Glaucoma ☐ Lung Disease ☐ Heart Murmurs ☐ Osteoporosis

☐ Headaches ☐ Gallbladder ☐ Hernia ☐ Anemia ☐ Measles ☐ Pleurisy ☐ Eczema

☐ AIDS

Current Medications

Over the counter medications (please list)

Prescription medications (please list)

Others/supplements (please list)

Please list any medication you are allergic to:

Please list any allergies and reactions: (include dietary allergies)

Previous Surgeries (all type) and approximate date:

Primary Care Physician Information:

In order to provide complete and wholesome care, we will communicate with your primary care physician regarding past, present, and future health concerns. By signing below, you authorize the Upper Cervical Spine Centers of Michigan to contact your physician, request medical records, and/or co-manage your healthcare needs

Signature of patient or guardian:

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Printed Name:

Consents

Email Communication
Transactional Emails

- [ ] Email 2 days before appointment

News and Special Promotions

- [ ] Yes, I would like to receive news and special promotions by email

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Intake Form — Consents

Accuracy of Information

- [ ] I certify that the above medical information is correct to my knowledge. *Required*

Privacy and Sharing of Information
I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- [ ] I agree *Required*

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctors' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

- [ ] I am aware of the Cancellation Policy. *Required*

Authorization & Privacy

Authorization Care I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges. The doctor will not be held responsible for any health conditions, or diagnoses that are pre-existing given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits to be directed to the doctor for all services rendered.

☐ I am aware of the Authorization & Privacy Policy *Required*

Healthcare Authorization Form

THE FOLLOWING AUTHORIZES UPPER CERVICAL SPINE CENTERS OF MICHIGAN TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS: I give permission to Upper Cervical Spine Centers of Michigan to use my name, address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, health related email messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings. I give permission to Upper Cervical Spine Centers of Michigan to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor in private, the doctor or therapist will provide a private room for these conversations. By signing the following you are giving Upper Cervical Spine Centers of Michigan permission to use and disclose your protected health information in accordance with the directives listed above.

☐ I am aware of the Healthcare Authorization *Required*

Acknowledgement of Receipt & Notice of Privacy Practices

I, understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following right and privileges: The right to review the notice prior to signing this consent The right to object to the use of my health care information for directory purpose The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment or health care operation.

☐ I acknowledge receipt and notice of privacy practices *Required*

Informed Consent for Chiropractic Treatment and Financial Agreement

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible by the doctor or intern affiliated with Upper Cervical Spine Centers of Michigan. I understand that, as in the practice of medicine, in the practice of chiropractic care 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. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests. Financial Agreement: I agree that in return for the services provided to me by the Upper Cervical Spine Centers of Michigan I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Upper Cervical Spine Centers of Michigan for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any insurance policy ensuring the patient or any other party liable to the patient are hereby assigned to the Upper Cervical Spine Centers

of Michigan. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. Upper Cervical Spine Centers of Michigan accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service. I also understand that if I cancel or fail to show up for a scheduled appointment at Upper Cervical Spine Centers of Michigan, I may be charged a cancellation fee which is at the discretion of Upper Cervical Spine Centers of Michigan. Assignment of Benefits: I agree that payments intended for the Upper Cervical Spine Centers of Michigan in return for services provided to me which are covered by my insurance policy and are sent to the undersigned patient or authorized recipient on behalf of the patient will be repaid to the Upper Cervical Spine Centers of Michigan. I have read, or have had read to me, the above consent. By signing below, I agree to the above and allow the doctor or intern, affiliated with Upper Cervical Spine Centers of Michigan to perform such. I intend this consent form and financial agreement to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

☐ I am aware of the informed consent for chiropractic treatment and financial agreement *Required*

Insurance Disclosure Form

Your health benefit plan may or may not provide in-or-out-of-network coverage for all the health care services you are scheduled to receive. Your health benefit plan may or may not reimburse a provider for all services provided if the provider is not in your health benefit plan network. You may be responsible for the costs of the services that are not covered by your health benefit plan. A nonparticipating provider must provide good faith estimates of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the healthcare services provided.
Services: Consultation, Examination and Necessary X-Rays Cost of the Above Services: $200-$375, depending on necessary X-Rays
You also have a right to request that the health care services be performed by a provider who participates with your health benefit plan network. You also may contact your carrier to arrange for those services to be provided at what may be a lower cost and to receive information on in-network providers who can perform the health care services you need.

☐ I have received, read, and understand this disclosure. *Required*

Supplemental Health Questionnaire - Chiropractic Treatment in Era of COVID-19

If you have been exposed to a communicable disease, you may spread the disease to the chiropractor, chiropractic staff or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission: Do you, your child, others accompanying you today or anyone else you have recently been in contact with have any of the following symptoms in the last 14 days? Fever (defined as above 100.4 degrees Fahrenheit) Chills Cough Sore Throat Shortness of breath and/or trouble breathing Persistent muscle pain, pressure, or tightness in the chest. New loss of taste or smell

Have you, your child, or others accompanying you today or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease in the last 14 days?
Have you or others accompanying you to today's appointment traveled outside of our local area or outside of the US within the past 14 days?
If you answered yes to any of these questions, please contact the office immediately to reschedule your appointment call 734-241-1111, or email hello@gentlespine.com

☐ I have answered no to all of the above. *Required*

Supplemental Informed Consent - Chiropractic Treatment in the Era of Covid-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, as known as "Coronavirus," at any time or in any place. Be assured, that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.
Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, chiropractor, or chiropractic staff and sometimes other patients at all times.
Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ I accept *Required*

Please check that all required questions have been answered.

Signature of patient or Guardian:

____

Name Printed:

____