.UP HEALTH

"For life, for wellness, for you!"

Name: _____ Date:_____
Address: _____ City, State, Zip:_____
Home Phone: _____ Cell Phone:_____
Birth Date: _____Age:_____ Social Sec #:_____
Employer:_____
Occupation: _____ Work Phone: _____
Marital Status: M S D W Spouse's Name: _____
Children's Names & Ages: _____ _____
_____ _____
_____ _____
Primary Care Physician: _____
Emergency Contact: _____ Relation: _____Phone:_____
_____
Current Health Complaints:
_____
_____

How did you hear about our office? _____

Primary Insurance:_____Secondary Insurance:_____

Is this a result of an Auto or Work Injury: Y N **If Yes…**
Name & address of Workman's Comp Carrier or Auto Insurance
_____
_____
Date of Injury_____ Claim #_____
Contact Person_____ Phone_____
Attorney Name, address & phone:
_____
_____

The information contained in this packet is true and accurate to the best of my knowledge. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize the release of any medical or other information necessary to process this claim. Please allow UP Health, PLLC to attain information on my medical history in order to better understand my condition. I also request payment of government benefits either to myself or to the third party who accepts assignment. Furthermore, I understand that UP Health will prepare any necessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid directly to UP Health will be credited to my account upon receipt. I clearly understand and agree that **I am personally responsible for payment.** I further authorize UP Health to call me at the above listed number for appointment reminders and other office matters.

_____ _____
Patient/Guardian Signature **Date**

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic and or acupuncture care.

_____
Signature

UP Health

When a patient seeks chiropractic care it is essential for both the patient and doctor to be working towards the same objective. It is important that the patient understand the method that will be used to attain this goal. This will prevent any confusion or disappointment. If you have any questions at *any time* during your care, we encourage you to ask Dr. Michael or Dr. Kristen as they are **always** happy to discuss them with you.

CHIROPRACTIC MEDICINE

Chiropractic medicine is made up of many tools and techniques. The most important tool *and* technique is the manual manipulation or the "adjustment". An adjustment is a specific application of forces to facilitate the body's correction of a mal-alignment of the joints in the body. Techniques used to aid the adjustment include but are not limited to: soft tissue techniques, stretching, rehabilitation exercises, nutritional advice and life-style advice. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts known, is in my best interests. I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing chiropractic procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

HEALTH

Health is the state of *optimal* physical, mental, and social well being, not merely the absence of disease or infirmity. Just because there are no symptoms does not mean that there is no problem. If the problem is caught early enough, it can be corrected with minimal pain or discomfort. If the problem is allowed to persist, irreversible changes may occur causing permanent damage and pain. Prevention is the key.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I request and consent to the performance of chiropractic adjustments and/or other chiropractic procedures on me or the minor in question by any licensed doctor of chiropractic who may be employed by or engaged in practice at UP Health.

_____ _____

Signature Date

Privacy Practices Acknowledgement:

I have received the Notice of Privacy Practices and have been given an opportunity to review it.

_____ _____

Signature Date

Please circle P if you've had this condition in the past, circle C if it is a current problem. Leave Blank if Never.

Health History

General
1. P C Fever
2. P C Chills
3. P C Night Sweats
4. P C Loss of Sleep
5. P C Fatigue
6. P C Nervousness
7. P C Weight Loss or Gain
8. P C Allergies
9. P C Bleeding Problems
10. P C Anemia
11. P C Diabetes
12. P C Cancer
13. P C Thyroid Disease/Goiter
14. P C Alcoholism
15. P C Drug Abuse
16. P C HIV Risk Factors

Eye, Ear, Nose, Throat
17. P C Poor Vision
18. P C Pain in Eye(s)
19. P C Difficulty Hearing
20. P C Nosebleeds
21. P C Nose Problems
22. P C Sinus Trouble
23. P C Dental Problems
24. P C Hoarseness
25. P C Tonsilectomy

Gastrointestinal
26. P C Poor Appetite
27. P C Poor Digestion
28. P C Difficulty Swallowing
29. P C Belching or Gas
30. P C Frequent Nausea
31. P C Vomiting
32. P C Vomiting Blood
33. P C Pain over Abdomen
34. P C Ulcer
35. P C Black or Bloody Stools
36. P C Liver Problems
37. P C Gall Bladder Problems
38. P C Jaundice
39. P C Hernia
40. P C Diarrhea
41. P C Constipation
42. P C Hemorrhoids
43. P C Appendicitis

Women Only
44. P C Live Births
45. P C Miscarriage
46. P C Painful Periods
47. P C Excessive Flow
48. P C Irregular Cycles
49. P C Vaginal Burning/Itching
50. P C Hot Flashes
51. Date Last Period Began: ___/___/___
52. Date of Last PAP Test: ___/___/___
53. Date of Last Mammogram: ___/___/___

Respiratory
54. P C Difficult Breathing
55. P C Chronic Cough
56. P C Spitting Phlegm
57. P C Spitting Blood
58. P C Wheezing/Asthma
59. P C Pneumonia
60. P C Tuberculosis

Cardiovascular
61. P C Irregular Heartbeat
62. P C High Blood Pressure
63. P C Pain Over Heart
64. P C Previous Heart Trouble
65. P C Ankle Swelling
66. P C Varicose Veins
67. P C Rheumatic Fever
68. P C Stroke

Genitourinary
69. P C Frequent Urination
70. P C Painful Urination
71. P C Blood in Urine
72. P C Kidney Disease
73. P C Urinary Infection
74. P C Inability to Control Urination
75. P C Difficulty Starting Urine Flow
76. P C Get up __times per night to urinate
77. P C Breast Lump or Pain
78. P C Venereal Infection
79. P C Sexual Difficulties

Skin
80. P C Itching
81. P C Bruising Easily
82. P C Change in Mole(s)
83. P C Skin Cancer

Neurologic
84. P C Weakness
85. P C Twitching
86. P C Tremors
87. P C Headache
88. P C Fainting
89. P C Dizziness
90. P C Convulsions
91. P C Epilepsy
92. P C Numbness/Tingling
93. P C Arm/Leg Pain
94. P C Mental Disorder

Men Only
95. P C Testicular Swelling/Pain
96. P C Prostate Problems

Accidents/Trauma
97. P C Motor Vehicle Accidents
98. P C Other Trauma/Accidents

Musculoskeletal
99. P C Neck Stiffness/Pain
100. P C Pain Between Shoulders
101. P C Low Back Pain
102. P C Swollen Joints
103. P C Painful Joints
104. P C Muscle Aches/Soreness
105. P C Spinal Curvature (Scoliosis)
106. P C Arthritis

Childhood Diseases
107. P C Mumps
108. P C Measles
109. P C Chicken Pox

Hospitalizations
110. List Dates and Reasons:
_____
_____
_____
_____

Surgeries
111. List Dates and Reasons:
_____
_____
_____
_____

Medications
112. P C Prescription
113. P C Non-prescription

Nutritional Status
114. P C Tell me about Your Nutrition
_____
115. P C Nutritional Supplements
_____
116. P C Herbs/Botanicals

Habits
117. P C Smoking ____packs/day
118. P C Drinking
119. P C Recreational Drug Use

Exercise (Circle)
120. None
121. 1-2 times a week
122. 3-5 times a week
123. 6-7 times a week

Family History (Circle)
124. Diabetes
125. Thyroid Disease/Goiter
126. Kidney Disease
127. High Blood Pressure
128. Heart Disease
129. Cancer
130. Muscle, Bone or Nerve Disease
131. Other

Continue on next page….

Symptoms/Injuries

If you are currently experiencing any of the following symptoms, please check:

☐ Arm/Shoulder Pain	☐ Feet/Toe Numbness	☐ Neck Pain
☐ Back Pain	☐ Hand/Finger Numbness	☐ Neck Stiffness
☐ Back Stiffness	☐ Headaches	☐ Shortness of Breath
☐ Chest Pain	☐ Irritability	☐ Sleep Difficulty
☐ Dizziness	☐ Jaw Problems	☐ Stomach Upset
☐ Ear Buzzing	☐ Leg Pain	☐ Tension
☐ Ear Ringing	☐ Memory Loss	☐ Vision Blurred
☐ Fatigue	☐ Nausea	

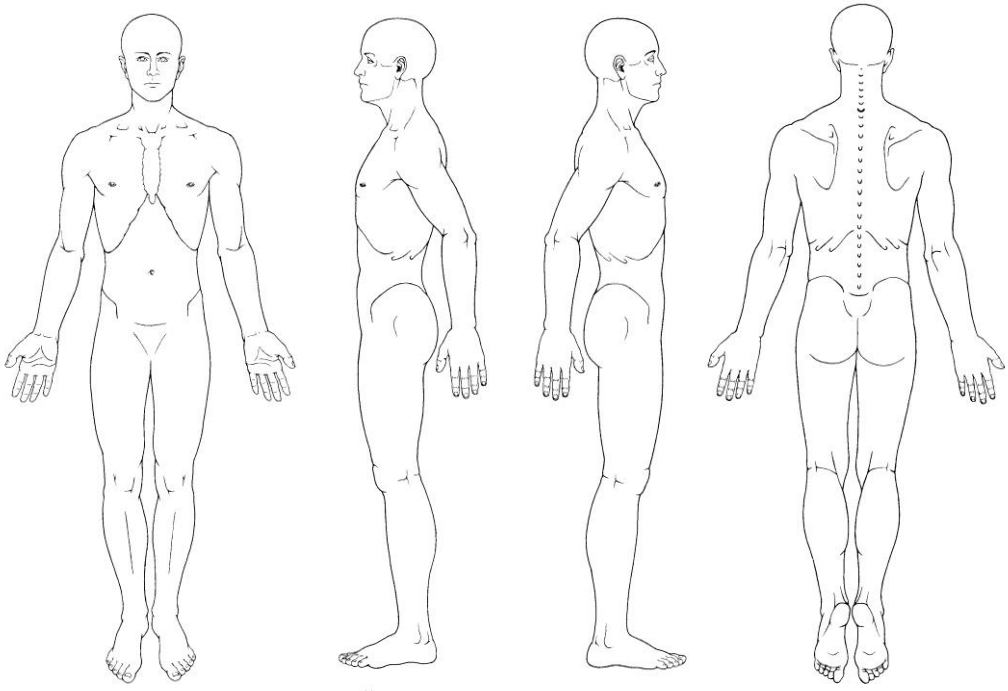
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Rate the severity of your pain on a scale from 1 (least pain) **to 10** (severe pain) _____
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your : ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Type of Pain:	☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
	☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
	☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other _____

Fill out below ONLY if this visit is due to an accident or work injury:

Have you been able to work since this injury? ☐ Yes ☐ No **How many work days have you missed?** _____
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

PAIN LOCATION



Please mark off the areas of your complaint on the diagram on the left. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Pain**
NNN	**Numbness**
TTT	**Tingling**
BBB	**Burning**
CCC	**Cramping**

I certify that the above information is correct to the best of my knowledge. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my insurance claim is denied.

Patient Signature: _____ **Date:** ____/____/_____

Notice of Privacy Practices

This notice takes effect on _____ and remains in effect until we replace it. This describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

POLICY ON MEDICAL INFORMATION:

The privacy of your medical information is extremely important to us and we are committed to protecting it. At our facility we keep thorough medical records pertinent to your case. These records help us maintain a high quality of care and allow us to comply with legal requirements. The following information is a notice of how we may use and share these records. Also contained in the following information are your rights and our duties regarding the disclosure of your medical information.

LEGALITY:

The law requires us to keep your information private and to notify you of this duty, our privacy practices and your rights regarding your medical information. We have the right to change our privacy practices and the terms of this notice at any time. We will inform you of any changes prior to enactment. These changes will apply to any of the medical records in our possession and any future records.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION:

The following are ways and descriptions of ways we use and may disclose your medical information. Other ways we may use or disclose your information will be done only after obtaining written permission from you, the patient. You may revoke any written authorization at any time by submitting a written revocation. This may be sent to us at 400 Main Street, Suite 2, Norway, MI 49870.

Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose this information to doctors, nurses, technicians, medical students or other professionals who are taking care of you. We may also share this information with your other healthcare providers to assist them in your treatment.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer (such as insurance). The information on or accompanying your bill may include medical information.

Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.

Facility Directory: Unless you notify us that you object, we will place your name, provider and your condition in general terms in our facility directory.

Notification: We may use or disclose your medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location or general condition. We will give you the opportunity to give permission or deny permission of this disclosure if possible. In case of emergency we will share only that information directly necessary to your care according to our professional judgment. We will also use our professional judgment in allowing someone to pick up medical supplies, X-rays or medical records on your behalf.

Disaster Relief: We may share information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: We may use your medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of your medical information.

Funeral Director, Coroner, Medical Examiner: In the event of your death, we may share the information of a deceased patient to help them in their duties.

Specialized Government Functions: We may disclose or use your health information for military personnel and veterans, for national security and intelligence activities, for protective services of the President, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances.

Public Health Activities: It is required by law that we disclose your medial information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposed of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products or to conduct activities required by the FDA. We may also, when authorized by law, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contacting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may use your information to notify the appropriate authorities in the event we have a reasonable belief that you are the victim of abuse, neglect or domestic violence or the possible victim of other crimes, if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

Workers Compensation: We may disclose medical information to comply with laws regarding workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to any agency providing health oversight activities authorized by law including audits, civil, administrative or criminal investigations or proceedings, inspections, licensure or disciplinary actions or other authorized activities.

Appointment Reminders: We may use your personal information to remind you of appointments whether it be by mail or phone unless you, in writing, revoke this privilege.

Alternative and Additional Medical Services: We may use your medical information to inform you of additional medical services or products that may be of benefit to you and to describe or recommend additional alternative treatments.

YOU HAVE A RIGHT TO:

1. Look at or get copies of your medical information. If you choose to have copies of your information, you may request a specific format, other than photocopying, unless it is impractical for us to do so. The request for copies must be submitted in writing. There will be a nominal charge for the copies to help us cover the cost.
2. Receive a list of all the times we have shared your information, for purposes other than mentioned above, and with whom it was shared.
3. Request additional restrictions, other than listed above, be placed on the distribution of your healthcare information. We do not need to grant this request, but if granted, it will be abided by except in the case of emergency.
4. Request, in writing, that we communicate with you about your medical information by different means or to different locations.
5. Request that we change certain parts of your medical information. This request must be made in writing. We may deny this request if we did not generate the information being requested to be changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. If we grant your request, we will make a reasonable attempt to tell others of the change, including people you list, and to include the changes in any future sharing of the information.

CONTACT US:

If you have a written request or feel that we have violated your privacy rights please contact us at:
400 Main Street
Suite 2
Norway, MI 49870
You may also file a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you file a complaint.