Dr. Lisa Upledger/ 900 E. Indiantown Road, Suite 310, Jupiter Florida 33477

Name_____Date_____
Address_____
City_____State_____Zip_____
PH#'s
Day_____Evening_____Cell_____
Date of Birth_____Male_____Female_____Age_____ Ins. Co._____
Single Widowed Divorced Spouse/Partner Name spouse/ partner_____
If referred, by whom_____Is this person a doctor or therapist? _____
Occupation_____Employer_____
Address_____Phone_____
MEDICARE INFORMATION:
Are you covered by Medicare? Yes_____No_____ Identification number_____
Is Medicare your primary insurance? Yes_____ No_____
If not who is your primary? _____
Whose is your secondary insurance co? _____
If you are on Medicare please read the attached page on Chiropractic Medicare Coverage Information.
MEDICARE INFORMATION:

Please read:
Payment is due at the time services are rendered and you are responsible for any fees regardless of insurance reimbursement. You will be provided with a receipt that contains the information to submit the claim to your insurance company. My main modality of treatment is CranioSacral Therapy (CST) and Chiropractic Manipulation Therapy (CMT). Not all insurance companies will reimburse on CST most usually do now on CMT but this is not guaranteed. SomatoEmotional Release work a part of CST is coded as 97799 which insurance companies will deny payment for.

Your signature below authorizes Dr. Lisa Upledger to release your records to insurance carriers that are processing your claims.

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561 746 5232

Accounts with outstanding balances that are not received within 3 months will be considered delinquent. In accordance with federal law delinquent accounts will have a 33% collection fee added to the balance.

If you are unable to keep your appointment, PLEASE provide 24 hours' notice of the cancellation or it may be necessary to bill you for your missed appointment. Thank you.

MY SIGNATURE CONFIRMS THAT I AM AWARE OF AN AGREE TO THE ABOVE.

Signature_____Date_____

If under 18, Name legal parent or guardian_____

Employer of parents/ guardian_____Occupation_____

Employer address_____Phone_____

_ Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. **Reasons for seeking care:**

Primary reason:

_____

Secondary reason:

_____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____

_____

_____

3. Past Health History:

A. **Please indicate if you have a history of any of the following:**
□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
□ None of the above

B. **Previous Injury or Trauma:**

_____

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Have you ever broken any bones? Which?

_____

C. **Allergies:** _____

D. **Medications:**

Medication Reason for taking

_____

_____

_____

_____

D. **Surgeries:**

Date Type of Surgery

_____ _____

_____

_____ _____

_____

E. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

_____ _____

_____

_____ _____

_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

▫ Cancer ▫ Strokes/TIA's ▫ Headaches ▫ Cardiac disease ▫ Neurological diseases

▫ Adopted/Unknown ▫ Cardiac disease below age 40 ▫ Psychiatric disease ▫ Diabetes

▫ Other _____ ▫ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death Age at death

_____

_____

_____

_____

Social and Occupational History:

A. **Job description:**

_____

B. **Work schedule:**

_____

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Jupiter Fl 33477
561 746 5232

C. **Recreational activities:**

_____

D. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

_____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
▫ Asthma/difficulty breathing ▫ COPD ▫ Emphysema ▫ Other _____ ▫ None of the above

_____

_____

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
▫ Heart surgeries ▫ Congestive heart failure ▫ Murmurs or valvular disease ▫ Heart attacks/MIs ▫ Heart disease/ problems ▫ Hypertension ▫ Pacemaker ▫ Angina/chest pain ▫ Irregular heartbeat ▫ Other _____
▫ None of the above

_____

_____

Have you had any of the following **neurological (nerve-related)** issues?
▫ Visual changes/loss of vision ▫ One-sided weakness of face or body ▫ History of seizures ▫ One-sided decreased feeling in the face or body ▫ Headaches ▫ Memory loss ▫ Tremors ▫ Vertigo ▫ Loss of sense of smell
▫ Strokes/TIAs ▫ Other _____ ▫ None of the above

_____

_____

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
▫ Thyroid disease ▫ Hormone replacement therapy ▫ Injectable steroid replacements ▫ Diabetes
▫ Other _____ ▫ None of above

_____

_____

Have you had any of the following **renal (kidney-related)** issues or procedures?
▫ Renal calculi/stones ▫ Hematuria (blood in the urine) ▫ Incontinence (can't control) ▫ Bladder Infections
▫ Difficulty urinating ▫ Kidney disease ▫ Dialysis ▫ Other _____ ▫ None of the above

_____

_____

Have you had any of the following **gastroenterological (stomach-related)** issues?
▫ Nausea ▫ Difficulty swallowing ▫ Ulcerative disease ▫ Frequent abdominal pain ▫ Hiatal hernia ▫ Constipation
▫ Pancreatic disease ▫ Irritable bowel/colitis ▫ Hepatitis or liver disease ▫ Bloody or black tarry stools
▫ Vomiting blood ▫ Bowel incontinence ▫ Gastroesophageal reflux/heartburn ▫ Other _____ ▫ None of the above

_____

_____

Have you had any of the following **hematological (blood-related)** issues?
▫ Anemia ▫ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ▫ HIV positive

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▫ Abnormal bleeding/bruising ▫ Sickle-cell anemia ▫ Enlarged lymph nodes ▫ Hemophilia
▫ Hypercoagulation or deep venous thrombosis/history of blood clots ▫ Anticoagulant therapy ▫ Regular aspirin use
▫ Other _____ ▫ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
▫ Significant burns ▫ Significant rashes ▫ Skin grafts ▫ Psoriatic disorders ▫ Other _____ ▫ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
▫ Rheumatoid arthritis ▫ Gout ▫ Osteoarthritis ▫ Broken bones ▫ Spinal fracture ▫ Spinal surgery ▫ Joint surgery
▫ Arthritis (unknown type) ▫ Scoliosis ▫ Metal implants ▫ Other _____ ▫ None of the above

Have you had any of the following **psychological** issues?
▫ Psychiatric diagnosis ▫ Depression ▫ Suicidal ideations ▫ Bipolar disorder ▫ Homicidal ideations ▫ Schizophrenia
▫ Psychiatric hospitalizations ▫ Other _____ ▫ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient or Guardian Signature _____

Date_____

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561 746 5232

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. A more detailed copy of this notice can be provided upon request.

_____ _____
Signature of Patient of Representative Printed Name

My PHI may be released and discussed with

_____ _____ _____

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

900 E. Indiantown Rd. Suite 310
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Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

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REQUESTS FOR SPECIAL CONFIDENTIAL COMMUNICATIONS PROCEDURES
FOR UPLEDGER CENTER FOR INTEGRATIVE THERAPY

I do_____ I do not _____ want any written communications sent to me
I do_____ I do not _____ want any telephone calls made e to me, it is ok_____ it is not ok_____ to leave a message on the answering machine or with whomever answers
I do_____ I do not_____ want emails sent to me
I do_____ I do not_____ want texts sent to me

1. I hereby request that all written communications be mailed only to the following address:

2. I hereby request that all telephone calls be made to this or these numbers:

3. I hereby request that all emails be sent to this or these email addresses:

4. I hereby request that all texts be sent to this or these phone numbers:

Patient's signature Date

Privacy Officer_____

Lisa Upledger/ 900 E. Indiantown Road Suite 310/ Jupiter Florida 33477

Informed Consent For Treatment:

Patient Name:

To the patient: Please read this prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:
One of the main modalities used as a Chiropractor is manipulative therapy mainly to the spine. This will be done by hands or with a mechanical instrument upon the body in such a way as to move the joints of the spine and upper and lower extremities. This may cause an audible “pop” or “click”, just the same as when one “cracks” their knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As part of the analysis, examination, treatment you are also consenting to the following procedures:

CranioSacral Therapy	Palpation	Neurological Testing
Range of motion Testing	Vital signs	Muscle strength Testing
Spinal Manipulative Therapy	Acupuncture	Postural Analysis
Muscle testing	Palpation	Orthopedic Testing
Joint Manipulation	Other	

The inherent risks in chiropractic adjustment:
As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation. These complications include but are not limited to fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Also some patients might feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The inherent risks in CranioSacral therapy:
There are very few risks involved in CranioSacral therapy as it is a light touch gentle treatment that works with your body's own inherent healing mechanisms, its aim being the improvement in function of a physiologic system. The risks are when there is a condition of increasing the intracranial pressure is contraindicated and those times are acute conditions of intracranial hemorrhage, an aneurysm, recent skull fracture and herniation of the brain stem.

The availability and nature of other treatment options:
Other treatment options for your condition may include self-administered over the counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers. At times hospitalizations or surgery might be needed.
If you choose one of the above "other treatment" options, you should be aware that there are risks and benefits of such options which I encourage you to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.
I have read ( ) or I have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Lisa Upledger and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to under go the treatment recommended. Having been informed of the risks I hereby give my consent to that treatment.

DATED: _____ DATED: _____

_____ _____
Patient's name Doctor's name

_____ _____
Signature Signature

_____
Signature for minor parent or guardian