E'TOWN CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. Thank You.

Date _____

Name _____ SS # _____ Home Phone _____

Street _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital Status: S M W D How Many Children _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife/Husband _____ Occupation _____

Employer _____ Office Phone _____

Other Nearest Relative _____ Phone _____

Heard about our office through _____

List present complaints, injuries and duration:

1. _____

_____

2. _____

_____

3. _____

Remarks and details of any accident/injury/problem.

Date of when the symptoms began.

_____

_____

_____

_____

List other doctors consulted for present complaints and injuries:

Name _____ When consulted _____

Diagnosis _____ Treatment _____

How long did you see the Doctor? _____ How frequently? _____

Results _____

Name _____ When consulted _____

Diagnosis _____ Treatment _____

How long did you see the Doctor? _____ How frequently? _____

Results _____

Present family doctor _____

Date of last physical examination _____ By Doctor _____

Check of you have any of the following conditions:

❒ Pacemaker ❒ Cancer ❒ Skin Eruptions ❒ Heart Condition ❒ Epilepsy

❒ Pregnant ❒ Nerve Damage/Stroke

❒ Metal Implants - Location _____

❒ Recently Ungergone Surgery - Please Specify _____

❒ Recent Serious Injury - Please Specify _____

❒ None of the above

What surgeries have you had

Type/When/Doctor/Remarks _____

_____

_____

List former serious accidents and falls: (auto, work, home, leisure, sports, other - circle one)

What/When/Symptoms/Treatment/Results _____

_____

_____

List broken bones:

What/When/Remarks _____

_____

_____

List medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/Remarks _____

_____

_____

Environment

Work - (Please circle appropriate answer)

Seated/Standing - Work Bench/Desk/Counter/Other _____

Job involves - Lifting/Bending/Stooping/Twisting/Turning/Carrying/Walking/Standing/Other _____

Chair - Executive/Steno/Bench/Stool/Folding/Other _____ Shoes - High heels/Boots/Other _____

Leisure

Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe) _____

_____

Strenuous activities? Exercise - Type/Frequency/Length of time? _____

_____

Sports - Type/Frequency/Length of time? _____

If you have discontinued sports or strenuous activities, why the change? _____

Exert Yourself - Frequently/Occasionally/Rarely/Never? Describe how? _____

_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❒	❒	❒	AIDS	❒	❒	❒	dislocated joints	❒	❒	❒	neck pain
❒	❒	❒	anemia	❒	❒	❒	epilepsy	❒	❒	❒	nervousness
❒	❒	❒	arthritis	❒	❒	❒	German measles	❒	❒	❒	numbness
❒	❒	❒	asthma	❒	❒	❒	headaches	❒	❒	❒	polio
❒	❒	❒	back pain	❒	❒	❒	heart trouble	❒	❒	❒	poor circulation
❒	❒	❒	bladder trouble	❒	❒	❒	reproductive disorders	❒	❒	❒	hepatitis
❒	❒	❒	bone fracture	❒	❒	❒	high blood pressure	❒	❒	❒	rheumatic fever
❒	❒	❒	cancer	❒	❒	❒	HIV/ARC	❒	❒	❒	rheumatism
❒	❒	❒	chest pain	❒	❒	❒	kidney disorder	❒	❒	❒	scarlet fever
❒	❒	❒	concussion	❒	❒	❒	bowel control loss	❒	❒	❒	serious injury
❒	❒	❒	convulsions	❒	❒	❒	menstrual cramps	❒	❒	❒	sinus trouble
❒	❒	❒	diabetes	❒	❒	❒	multiple sclerosis	❒	❒	❒	tuberculosis
❒	❒	❒	indigestion	❒	❒	❒	muscular dystrophy	❒	❒	❒	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes ❒ No ❒

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

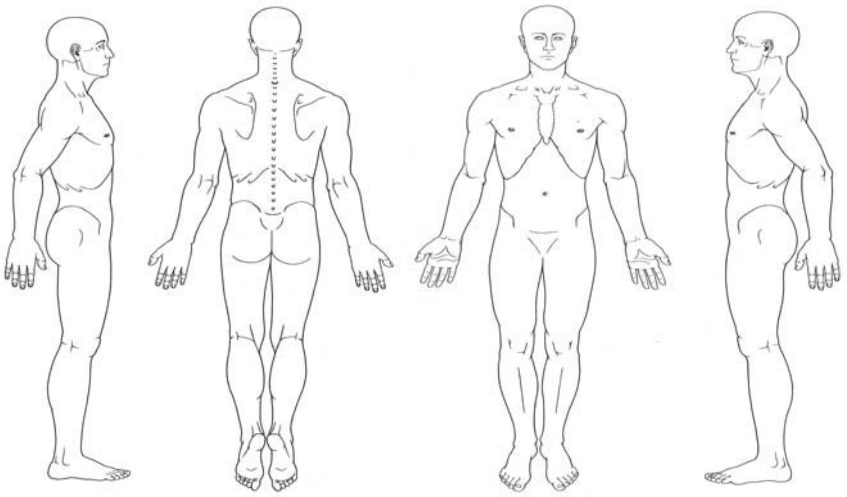
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

All the information that I have provided is true and factual to the best of my knowledge.

Signature _____ Date _____

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable. I also agree to pay any and all expenses the Doctor may incur for the collection of my account.

Patient's Signature _____ S.S. # _____ Date _____

Other Responsible Party ___ _____ S.S. # _____ Information taken by _____

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ , hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a post card mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and necessary for the Practice to conduct specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor) Relationship

_____ _____