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one

WELCOME

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
 LAST FIRST MI

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? _____

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two

INSURANCE INFO

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

Please describe the pain & its location: _____

When did condition begin? ____ / ____ / ____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, whom? _____ Phone#: _____

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PLEASE CONTINUE ON BACK

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IN EVENT OF EMERGENCY

Who should we contact? _____
 Relation: _____
 Home Phone #: _____ Work Phone #: _____
 Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Family Health History: _____

Do you: Take Supplements or Vitamins? ☐ Yes ☐ No / Exercise? ☐ Yes ☐ No

Are you on a special diet: ☐ Yes ☐ No / Since: ____ / ____ / ____

Do you smoke? ☐ No ☐ Yes / How Much? ____ How Long? ____

Are you wearing: ☐ Heel Lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress? ____ Is it comfortable? ☐ Yes ☐ No

For women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes/How long? ____ Nursing? ☐ Yes ☐ No

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ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY _____ STATE _____ ZIP _____

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: ☐ CASH ☐ Check

☐ Credit Card: Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).



PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____ / ____ / ____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

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one

AUTO / WORK RELATED ACCIDENT

2a

ABOUT YOU

Today's Date: / / File #:

Name:

2b
two b

WORK RELATED ACCIDENT

Date & Time of Accident: ☐ a.m. ☐ p.m.

Was your accident directly related to your work?

☐ Yes ☐ No

Briefly describe the events that occurred just before and during your accident:

Give the address where accident occurred: (if other than employer's address)

Was anyone else present during your accident?

☐ Yes ☐ No

Did you report your accident to your employer?

☐ Yes ☐ No

What recommendations did your employer make just after your accident?

Has this type of accident happened to you before?

☐ Yes ☐ No

To the best of your knowledge, has this accident occurred in your workplace before?

☐ Yes ☐ No

In general:

Is your job physically stressful? ☐ Yes ☐ No

Is your job mentally stressful? ☐ Yes ☐ No

Is your workplace noisy? ☐ Yes ☐ No

Have you changed jobs in the last year? ☐ Yes ☐ No

AUTO RELATED ACCIDENT

Date & Time of Accident: ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued?

Number of people in accident vehicle?

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing your seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain:

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe:

Make & model of the vehicle you were occupying?

Name of the location/street on which you were traveling?

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle?

Did the impact to your vehicle come from the:

☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle...

Make and model of that other vehicle?

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Speed of the other vehicle?

In your words, please describe the accident:

PLEASE CONTINUE ON BACK

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AFTER INJURY

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a Hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance or ☐ Private transportation

Name of Hospital and/or Attending doctor: _____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received: _____

Were X-rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury?

☐ Yes ☐ No

Indicate ☒ the symptoms that are a result of this accident:

- | | | | |
|-----------------------------------------|----------------------------------------------|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Arms/Shoulder pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numb Hands/Fingers | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Back stiffness |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Numb Feet/Toes |
| <input type="checkbox"/> Other _____ | | | |

Is your condition getting worse?

☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable <small>even if only sometimes</small>	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom: _____

His/Her Phone #: _____

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RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

Please indicate ☒ your daily job duties and any activities which you are occasionally asked to perform.

- | | | |
|-----------------------------------|-----------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving | <input type="checkbox"/> Operating equipment |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting | <input type="checkbox"/> Work with arms above head |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Crawling | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending | <input type="checkbox"/> Stopping |

☐ Other _____

What positions can you work in with minimum physical

effort and for how long? _____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? . . ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

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ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. / /

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

_____/_____/_____
SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

Patient Name _____

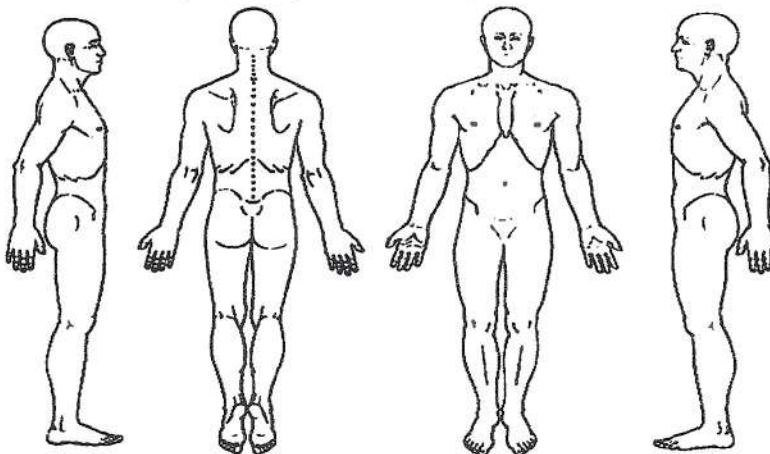
Date _____

1. When did your symptoms start: _____

Describe your symptoms and how they began:

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



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. How bad are your symptoms at their:

- a. worst:* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable*

6. How do your symptoms affect your ability to perform daily activities?

- | ⑩ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ |
|---------------|---|----------------------------------|---|---------------------------------------|---|-------------------------------------|---|---------------------------------------------|---------------------------------|
| No complaints | | Mild, forgotten
with activity | | Moderate, interferes
with activity | | Limiting, prevents
full activity | | Intense, preoccupied
with seeking relief | Severe, no
activity possible |

7. What activities make your symptoms worse:

8. What activities make your symptoms better:

9. Who have you seen for your symptoms?

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

a. When and what treatment?

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: _____

10. 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 ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

11. What is your occupation?

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

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

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

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms ③ Explanation of condition/treatment ⑤ How to prevent this from occurring again
② Resume/increase activity ④ Learn how to take care of this on my own ⑥

Patient Signature _____

Date _____