# 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? _____

## 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#: _____

## three

PLEASE CONTINUE ON BACK

four

## IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

five

## 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

six

## 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
Initials 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).

- 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

# 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:***

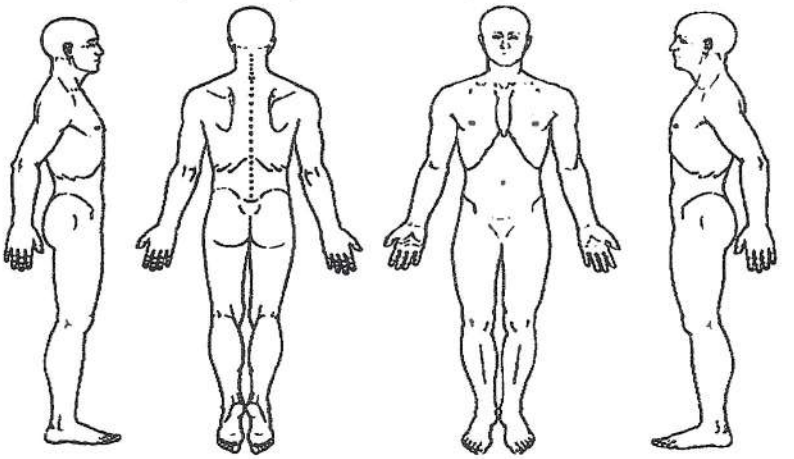
_____

_____

***2. How often do you experience your symptoms?***

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. How bad are your symptoms at their:***

| | *None* | | | | | | | | | | *Unbearable* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ***a. worst:*** | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| ***b. best:*** | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

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

| ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
|---|---|---|---|---|---|---|---|---|---|---|
| *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
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

*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
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

***11. 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

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

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

***Patient Signature*** _____ ***Date*** _____