WELCOME
PATIENT INFORMATION

DATE:__________

PATIENT____________________________ DOB_____/_____/___________

ADDRESS________________________________ ___ _______________
street city state zip

SEX: ____M ____ F PATIENT SS#____________ MARITAL STATUS:__________

OCCUPATION:______________________________________

EMPLOYER:____

____
street city state zip

EMPLOYER PHONE__________________________________

SPOUSE NAME:_____________________________________

BIRTHDATE:___________ SS#:____________________

HOME PHONE:__________________ CELL_____________ E-MAIL_______________

WORK__________________________

IN CASE OF EMERGENCY:___________________________
NAME

____
RELATIONSHIP PHONE NUMBER

HOW DID YOU HEAR ABOUT US:____

MEDICATIONS:____

ALLERGIES:____

HEIGHT:__________________ WEIGHT:____________________

PRIMARY DOCTOR:_______________________________________

EXERCISE:_____NONE_____MODERATE_____DAILY_____HEAVY

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

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 past 4 weeks:

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 past 4 weeks 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

8. Who have you seen for your symptoms?

① No One ② 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 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** ______________

Patient Health Questionnaire - page 2

Managed Physical Network

MPN Use Only rev 5/7/99

Patient Name ______________________ *Date* ______________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Feet Inches Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke	○	○	Smoking/Use Tobacco Products
○	○	Low Back Pain	○	○	Angina	○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones	○	○	Allergies
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Depression
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Systemic Lupus
○	○	Hand Pain	○	○	Painful Urination	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Loss of Bladder Control	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain	○	○	Prostate Problems	○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			***Females Only***
○	○	Jaw Pain	○	○	Loss of Appetite	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Abdominal Pain	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Ulcer	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Hepatitis	○	○	
○	○	General Fatigue	○	○	Liver/Gall Bladder Disorder			***Other Health Problems/Issues***
○	○	Muscular Incoordination	○	○	Cancer	○	○	
○	○	Visual Disturbances	○	○	Tumor	○	○	
○	○	Dizziness	○	○	Asthma	○	○	
			○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ ______________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

______________ ______________ ______________

______________ ______________ ______________

List all the surgical procedures you have had and times you have been hospitalized:

______________ ______________ ______________

______________ ______________ ______________

Patient Signature ______________________ ***Date*** ______________

Provider's Additional Comments

____

____

____

Doctors Signature ______________________ ***Date*** ______________

<u>Patient Condition</u>

PATIENT NOTIFCATION OF FINANCIAL RESPOSIBILTY

I understand that I may be financially responsible for any charges incurred at this office, Including co-pays, deductibles, and any charges denied or not covered by my insurance company.

I realize that my care may be subject to preauthorization by my insurance company, and I accept all responsibility for any treatments, which are determined not to be medically necessary. I understand that my coverage may not cover routine maintenance, preventative or wellness visits.

In addition, I realize that if I do not have the proper referral that I will be responsible for all charges incurred.

Insurance policy limitations are per individual policy plan, as are co-payments, co-insurance, deductibles and referral policies.

I have read and understand my obligations for payments for the care in the absence of insurance coverage.

______________________________ ______________________________

PRINT PATIENT'S NAME SIGNATURE patient, parent, or guardian

Female Patients To the best of my knowledge, I am not pregnant and Mid-Hudson Chiropractic has the permission to x-ray my body if necessary.

Patient Signature______________________**Date**__________

Patients Under 18 I hereby authorize Mid-Hudson Chiropractic to administer care as they Deem necessary to my son/daughter

Patient's Signature__________________ **Date**____________

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. I authorize any holder of medical or other information about me to my doctor, insurance carrier or their intermediaries, any information necessary for my medical care or to process this health related insurance claim.
I hereby authorize payment of benefits to be made directly to Mid-Hudson Chiropractic. I permit a copy to this authorization to be in place of the original. I understand that all fees for services rendered are my responsibility regardless of insurance coverage. All fees not paid by my insurance carrier are to be paid in full by me. I understand that if the account is not paid within 90 days it is my responsibility to either pay the claim myself or to contact the insurance company. I understand it is my responsibility to inform this office of any change in my personal information. (I.e. address, phone number, insurance information, medical status, exc.)

PATIENT SIGNATURE______________________________DATE______________

INFORMED CONSENT

Any procedure intended to help may also do harm. While chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy). Are usually considered remarkably safe and effective. Please understand that occasionally there are complications. While the chances of experiencing any of these complications are extremely small it is the practice of this chiropractic office to fully inform and educate all our patients about them. These complications include but are not limited to:

Pain	Disc injury	Burns
Swelling	Senory changes	Soft tissue injury
Bruising	Bleeding	Stroke (CVA)
Discoloration	Bone Fracture	Dizziness
Inflammation	Nausea	Weakness

Worsening of the condition and spinal cord damage:

I understand that there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible risk attendant to my case.

Signature____

Date____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

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

Name ______________________________ Birthdate ______________

Signature ____

Date ____

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