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

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

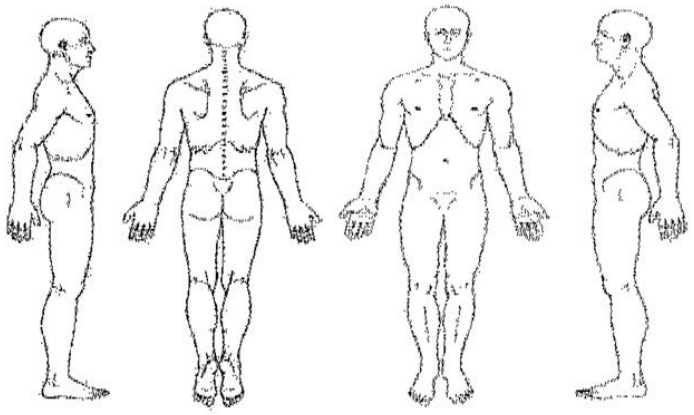
a. When did your symptoms start? _____

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 ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

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 ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. 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

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

Patient Name _____ ***Date*** _____

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

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

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

WORKERS' COMPENSATION INFORMATION

NAME:_____ DATE OF ACCIDENT:_____

1. Name of employer at time of accident:_____

2. Type of work being done at time of accident:_____

3. In your own words, please describe accident:_____

_____

_____

4. Have you been treated by another doctor for this accident? ____yes _____no

If yes, please list doctor's name, address: _____

What type of treatment did you receive? _____

5. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
_____ yes _____no _____ don't know

If yes, please describe: _____

_____

_____

6. Have you returned to work since this accident? _____yes _____no
If yes, Date_____ Regular duty _____ Light duty _____

7. Check symptoms you have noticed since accident:

____Headache	____Irritability	____Numbness in toes	____Face flushed	____Feet cold
____Neck Pain	____Chest Pain	____ Shortness of breath	____Buzzing in ears	____Hands cold
____Neck Stiff	____Dizziness	____Head seems heavy	____Loss of memory	____Stomach upset
____Fatigue	____Back pain	____Sleep problems	____Depression	____Light bothers eyes
____Fainting	____Nervousness	____Loss of smell	____Tension	____Pins & needles arm
____Fever	____Cold sweats	____Loss of taste	____Diarrhea	____Pins&needle legs
____Ears ring	____Constipation	____Loss of balance	____Ears Buzzing	____ Numbness/ fingers

Symptoms other than above: _____

Attorney's Name: _____ Address:_____

Patient signature: _____ Date: _____

Patient Condition

PATIENT NOTIFCATION OF FINANCIAL RESPOSIBILTY

I understand that I may be financially responsible for any charge 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

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 _____

Mid-Hudson Chiropractic Health Services, PC
Dr. Joseph Olmo, D.C.
P.O. Box 86
Hopewell Junction, N.Y. 12533
(845) 221-3555