Patient Information Sheet

Date: _____ Birth Date: _____ ☐ Male ☐ Female Patient #: _____

Patient Name: _____
(Last) (First) (MI)

Address: _____ City:_____ State:_____ Zip: _____

Phone #: (_____)_____-_____ Email Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Seperated

Who may we thank for referring you?: _____

Inital: **Assignment of Insurance Proceeds**

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, x-rays, diagnostic testing or any other reimbursable treatment or evaluations you receive to our clinic directly.

In exchange for services and supplies rendered, I do assign to the treating physician any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claims awards up to the amount of any unpaid balance on my account.

Inital: **Records Release Authorization**

You are authorized to release any information contained in my file to any insurance company, attorney, adjuster, or office staff, including any contracted billing services representing the clinic, in order to process any claim for reimbursement of charges incurred for rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed third parties should phone contact be required for the purpose of obtaining payment for charges outstanding.

Signiature: _____

Printed Name: _____

Date: _____

Inital: I consent to receiving text messages. Message and Date Rates may apply. Reply STOP to opt-out of future messaging or reply HELP for additional messaging help. Messaging frequency may be up to 5 messages per month.

Patient Health Questionnaire – page 2

Patient Name _____ Date _____

What type of regular exercise do you perform? ○None ○Light ○Moderate ○Strenuous

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

Ever had a Mammogram? ○ Yes ○ No

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

○Rheumatoid Arthritis ○Heart Problems ○Diabetes ○Cancer ○Lupus ○other _____

Smoking History: ○ Never Smoked ○ Previous smoker, how long since you last smoked _____

○ Current smoker, how many per day _____

Current smokers: Would you like information on smoking cessation? ○ Yes ○ No

Any drug allergies? ○ Yes ○ No If yes, please list your allergies _____

_____

Patients older than 65, have you ever had a pneumonia vaccine? ○ Yes ○ No

Are you currently taking any medications? ○ Yes ○ No If yes, please list the name of the drug and dosage _____

_____

Have you had any surgical procedures or ever been hospitalized? ○ Yes ○ No

If yes, please list the procedures and dates _____

_____

Patient signature: _____ Office Use Only/Account Number: _____

Patient Health Questionnaire - PHQ

Form PHQ-202

rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

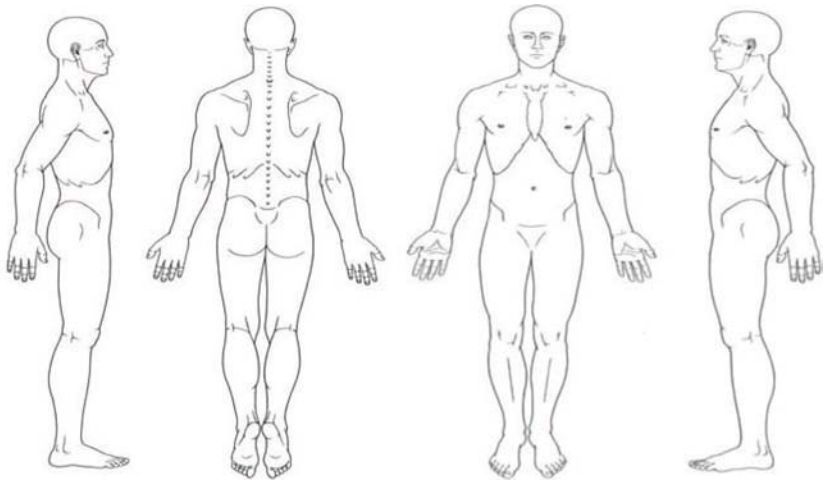
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- ○ Constantly (76-100% of the day)
- ○ Frequently (51-75% of the day)
- ○ Occasionally (26-50% of the day)
- ○ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ○ Sharp ○ Shooting
- ○ Dull ache ○ Burning
- ○ Numb ○ Tingling

4. How are your symptoms changing?

- ○ Getting Better
- ○ Not Changing
- ○ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ *Unbearable*

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

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ 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)

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

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

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

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8. Who have you seen for your symptoms?

○ No One ○ Medical Doctor ○ Other
○ Chiropractor ○ Physical Therapist

a. What treatment did you receive and when? _____

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

○ Xrays *date:* _____ ○ CT Scan *date:* _____
○ MRI *date:* _____ ○ Other *date:* _____

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

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

○ This Office ○ Medical Doctor ○ Other
○ Chiropractor ○ Physical Therapist

10. What is your occupation?

_____

○ Professional/Executive ○ Laborer ○ Retired
○ White Collar/Secretarial ○ Homemaker ○ Other
○ Tradesperson ○ FT Student

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

○ Full-time ○ Self-employed ○ Off work
○ Part-time ○ Unemployed ○ Other

Patient Signature _____ **Date** _____

Mahtomedi Chiropractic Clinic

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NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for announcements and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date
_____	
Date	