Allie Chiropractic Clinic

1654 Rice Street • St. Paul, MN 55117

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	

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PATIENT INFORMATION SHEET

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Date ___________________ Patient Name ____ Patient # __________
☐ Male ☐ Female (Last) (First) (MI)
SSN _________________________ Birth date ______________________ Home phone (_____)_______________

Cell phone (_____)____________________ Email address ____

Address ______________________________________ City ___________________ State ______ Zip __________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Minor-parent's name ____ Birth date ____________________

Patient's or Parent's Employer __________________________________ Work phone (_____)_______________

Person to contact in case of emergency _____________________________ Phone (_____)__________________

Whom may we thank for referring you? ____

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We ask you to make every effort to be here for your scheduled appointments because these appointments are important for your continued improvement.

If you are satisfied with the care you receive we ask that you try to refer a friend or relative so that they may also benefit from improved health and well being.

If you are not satisfied with the care you receive we ask that you please give us suggestions about how we can improve.

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A service charge of 1.5% per month 18% APR will be added to all overdue accounts. Also you will be liable for all legal and collection fees. **ALL COPAYS ARE DUE AT THE TIME OF YOUR VISIT**.

X ____ ________________________________
Signature of patient or parent if minor Date

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 _____

_____

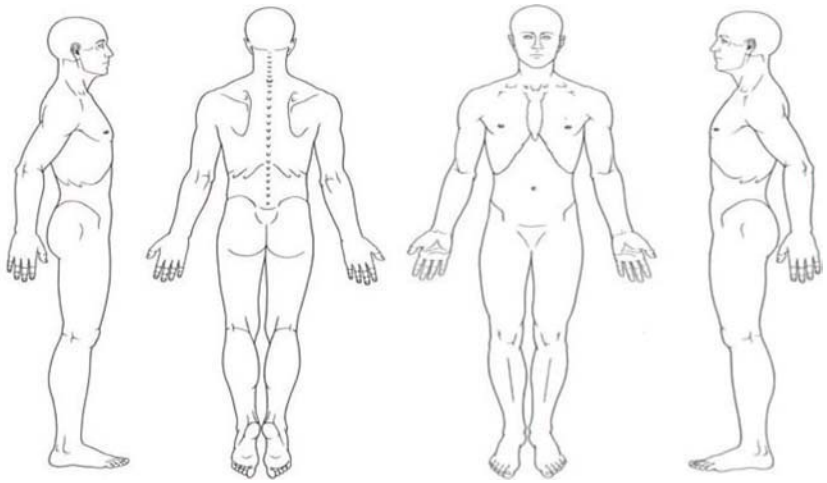
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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*** _____