



Patient Registration
Patient Information

Name (Last, First) _____ SS# _____
Address _____ City _____ State _____ Zip Code _____
Preferred Phone _____ Home Phone _____ Cell Phone _____
Date of Birth ____/____/____ Marital Status: Single Married Divorced Widowed
Emergency Contact/Parent Name _____ Phone _____

How did you hear about our office? _____

What form of insurance will we be billing for you? [] Personal [] Worker's Comp [] Automobile
[] Medicare [] None

Patient Consent

_____ I authorize the performance of diagnostic tests, procedures, and treatment deemed necessary by my Doctor of Chiropractic or other personnel involved in my care.

_____ I have read and acknowledge the following: Doctors of Chiropractic using manual therapy treatments for patients with headache and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 out of 400,000 treatments to 1 out of 10 million treatments. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disc injuries, or physiotherapy burns. These are extremely rare occurrences.

_____ I authorize this health care facility to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. If I fail to pay charges incurred, any outstanding debt will be submitted to a collection agency until paid in full.

_____ I am aware that I am financially responsible for a \$15 no-show fee if I do not notify Spine and Sports Chiropractic 2 hours prior to a missed appointment more than twice per calendar year.

HIPAA Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information will be used to: 1) conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, 2) obtain payment from third-party payers, and 3) conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I acknowledge receipt of a copy of the office 'Notice of Patient Privacy Policy'.

Signature _____ Date _____

Relationship to Patient (if under 18) _____

Electronic Health Records

First Name: _____ Last Name: _____

Preferred method of communication for patient reminders (Check one):

___ Cell phone: _____ Cell Phone Provider: _____

___ Email address: _____ @ _____

DOB: ___/___/___ Gender : Male / Female Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

| Family Medical History (Record one diagnosis in your family history and the affected) | | | | |
|--|--------|--------|---------|-----------|
| Diagnosis | Father | Mother | Sibling | Offspring |
| Example: Heart Disease | | | | |
| | | | | |

| Are you currently taking any prescribed or over the counter medications (vitamins excluded)? | |
|---|--|
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
| | |
| | |

| Do you have any medication allergies? | | | |
|--|----------|------------|---------------------|
| Medication Name | Reaction | Onset Date | Additional Comments |
| | | | |
| | | | |

I choose to decline receipt of my clinical summary after every visit

(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

| | | |
|----------------------------|---------------|-----------------------------|
| For office use only | | |
| Height: _____ | Weight: _____ | Blood Pressure: _____/_____ |

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

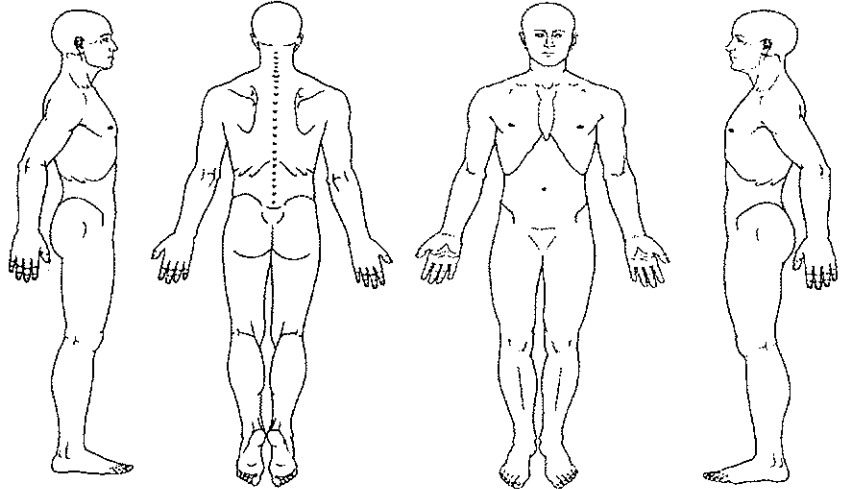


Patient Name: _____ Date: _____

1. When did your symptoms start: _____ Describe your symptoms and how they began:

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



3. What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling
- Weak
- Tightness
- _____

4. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

5. How bad are your symptoms at their:

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

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

- ① No complaints ② Mild, forgotten with activity ③ Moderate, interferes with activity ④ Limiting, prevents full activity ⑤ Intense, preoccupied with seeking relief ⑥ 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?

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

a. When and what treatment?

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

- Xrays date: _____
- MRI date: _____
- CT Scan date: _____
- Other date: _____

10. 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
- Other Chiropractor
- Physical Therapist

11. What is your occupation?

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

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

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

- Reduce symptoms
- Resume/increase activity
- Explanation of condition/treatment
- Learn how to take care of this on my own
- How to prevent this from occurring again
- Other

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ACN Group, Inc PHQ-102



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

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

Rheumatoid Arthritis Heart Problems Diabetes Cancer Auto Immune _____

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

Doctor's Additional Comments

Sign: _____ **Date:** _____

Updated/Reviewed

Date: _____ Initial: _____ Doctor: _____ Date: _____ Initial: _____ Doctor: _____

Date: _____ Initial: _____ Doctor: _____ Date: _____ Initial: _____ Doctor: _____