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: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White (Caucasian)

☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

Smoking Status: ☐ 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:_____/_____

In compliance with Medicare requirements for the government EHR incentive program

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 $25 **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)*** _____

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

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

Patient Name:_____ **Date:**_____

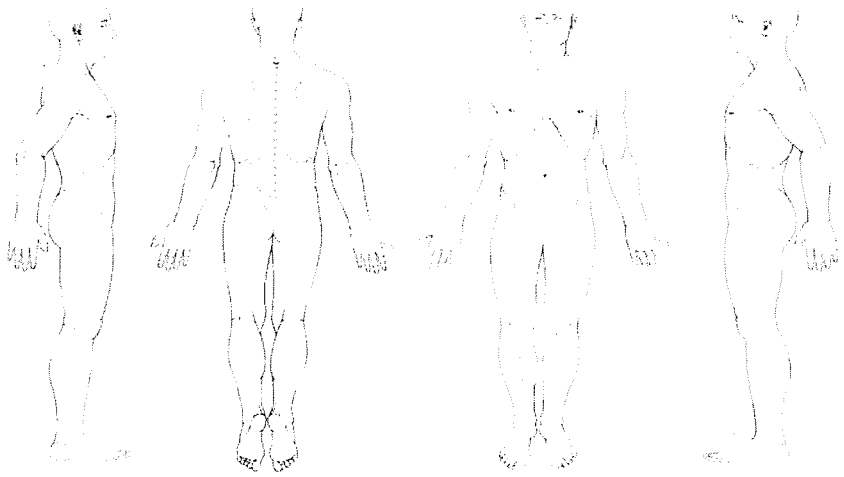
1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

_____

2. How often do you experience your symptoms?

- ◯ 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 ☐ Weak
- ☐ Dull ache ☐ Burning ☐ Tightness
- ☐ Numb ☐ Tingling ☐ _____

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
b. best:	◯	◯	◯	◉	◯	◯	◯	◯	◯	◯	◯

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

◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
No complaints	*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*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 ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

a. When and what treatment? _____

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

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *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 ☐ 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

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

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

Patient Health Questionnaire - Page 2

ACN Group, Inc PHQ-102

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

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	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	

Other Health Problems/Issues

☐ ☐ _____

☐ ☐ _____

☐ ☐ _____

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_____