

**PATIENT FINANCIAL INFORMATION:** please print

TODAY'S DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

CELL PHONE: (\_\_\_\_) \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MARITAL STATUS: ( ) S ( ) M ( ) W ( ) D SEX: F M E-MAIL: \_\_\_\_\_

DRIVER'S LICENSE NUMBER: \_\_\_\_\_ STATE: \_\_\_\_\_ RESTRICTIONS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

NAME OF CLOSEST RELATIVE (other than spouse): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

REFERRED TO OUR OFFICE BY: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**FINANCIAL INFORMATION:** (how you choose to pay for services rendered)

( ) HEALTH INSURANCE: NAME OF INSURANCE COMPANY: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ INSURED'S ID NUMBER: \_\_\_\_\_

( ) AUTO INSURANCE (fill out auto accident form)

( ) WORKMAN'S COMPENSATION INSURANCE (fill out work comp form)

( ) CASH \_\_\_\_ AT TIME OF SERVICE \_\_\_\_ NEED TO DISCUSS PAYMENT ARRANGEMENT

PATIENT/RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO TREAT MINOR:**

I hereby give permission to Dr(s): \_\_\_\_\_

To render chiropractic treatment to my ( ) son ( ) daughter ( ) \_\_\_\_\_

( ) PARENT ( ) GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF AN EMERGENCY:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

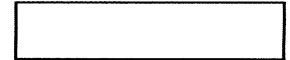
ADDRESS: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

**PLEASE READ AND SIGN BACK**

CHOOSE ONE

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202



ACN Group, Inc. Use Only rev 7/18/05

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

\_\_\_\_\_  
\_\_\_\_\_

a. When did your symptoms start?

\_\_\_\_\_

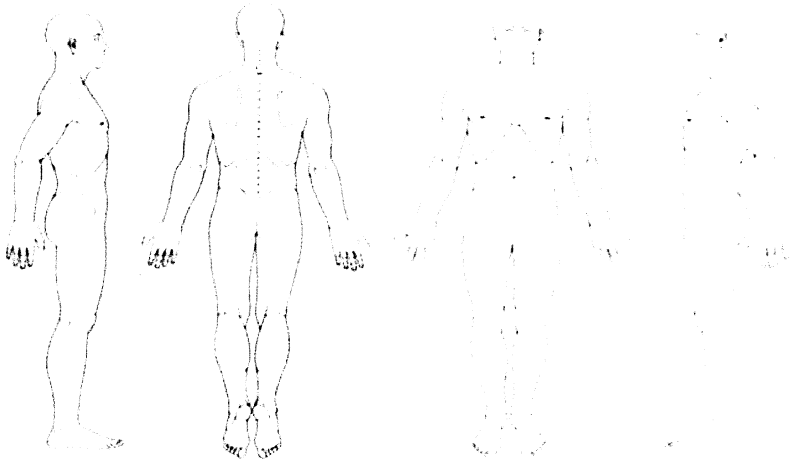
b. How did your symptoms begin?

\_\_\_\_\_

## 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
- (2) Dull ache
- (3) Numb
- (4) Shooting
- (5) Burning
- (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 \_\_\_\_\_

## PATIENT INTAKE FORM (Page 2)

**11. Do you consider this problem to be severe?**

- Yes                       Yes, at times                       No

**12. What aggravates your problem?**

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**13. What concerns you the most about your problem; what does it prevent you from doing?**

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**14. What alleviates your problem?**

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**15. What is your:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

**16. What type of exercise do you do?**

- Strenuous                       Moderate                       Light                       None

**17. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis                       Diabetes                       Lupus  
 Heart Problems                       Cancer                       ALS

**18 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/Tobacco Use
<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 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"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<b>For Females Only</b>	
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**19. List all prescription medications you are currently taking:**

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**20. List all of the over-the-counter medications you are currently taking:**

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**21. List all surgical procedures you have had:**

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**22. What activities do you do at work?**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

**23. What activities do you do outside of work?**

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**24. Have you ever been hospitalized?**     No     Yes

if yes, why \_\_\_\_\_

**25. Have you had significant past trauma?**     No     Yes

**26. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Office Procedures and Patient Financial Responsibility

In order to prevent any misunderstanding regarding the office's scheduling, billing and insurance policy, we would like our patients to be aware of the following:

- 1) As a COURTESY Rejuvenate Chiropractic Spa will bill the insurance company and wait for payment, for its current treating patients. We will do everything possible to get accurate insurance information, inform the patient of their benefits, and collect from the insurance company in a timely manner. However, should there be a problem with the insurance company payment, the patient will be notified. Our office will assist the patient and provide necessary phone numbers and contact information. After 30 days, if the insurance company has not paid, the bill will be due and payable and the patient will be billed directly.  
\_\_\_\_\_ (Initial)
- 2) The patient is responsible for deductibles and co-payments (whatever portion of the bill the insurance does not cover) at the time of the visit.  
\_\_\_\_\_ (Initial)
- 3) The patient is responsible for all supplements and supplies at the time of the visit. Insurance companies generally do not pay for supplies or supplements. If the supplements and supplies are paid for by the insurance company, the patient will either be reimbursed by the office or payment will be credited to the patient's account. \_\_\_\_\_ (Initial)
- 4) For your convenience, our office accepts credit card payments. We are always happy to receive cash payments. We realize that it may be inconvenient to make a payment at each office visit. Therefore, our policy is that all fees be paid on the last visit of each week, or by written agreement with a staff member. \_\_\_\_\_ (Initial)
- 5) It is our office policy not to carry co-payments or any other balances over one hundred fifty dollars other than expected insurance reimbursements.  
\_\_\_\_\_ (Initial)
- 6) It is our office policy that there is a missed visit fee of twenty-five dollars for massage and acupuncture appointments. This fee will be incurred if a cancellation of appointment phone call is not made at least 24 hours in advance as a courtesy to our other patients.  
\_\_\_\_\_ (Initial)
- 7) If you discontinue your care and treatment for any reason other than being discharged by the doctor, all fees for services rendered will be due and payable immediately. \_\_\_\_\_ (Initial)
- 8) I understand that I am ultimately responsible for all fees for services rendered.  
\_\_\_\_\_ (Initial)

Your cooperation is truly appreciated. If you have any questions, please feel free to discuss them with our Office Manager. We thank you for staying current with your payments at our office.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT NAME (please print): \_\_\_\_\_

