COLLEYVILLE CHIROPRACTIC

Patient Demographics File:

Patient Identification

Name _____

Street Address _____

City, State, Zip _____

Date of Birth _____

Primary Phone # _____ mobile / home / work

Secondary Phone # (optional) _____ mobile / home / work

Email _____

I authorize Colleyville Chiropractic to contact me and leave voice and/or text messages for the purpose of appointment reminders and information about about my health care treatment.

_____ **Initial**

Family Information

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name _____

Emergency Contact Person _____ Relationship _____

Phone # _____

Financial

How do you intend to pay for today's services?

☐ Insurance ☐ Self-Pay ☐ Discount Network (PCD)

Patient Signature _____ **Date** _____

New Patients Only

How did you hear about us?

☐ Patient Referral: _____

Our office sends thank you cards to our patients when they refer their friends and family.

☐ Please check here if you do not want your visit mentioned to the referral source.

☐ Doctor Referral: _____

☐ Insurance Referral ☐ Web Search ☐ Location/Sign

☐ Other: _____

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:***

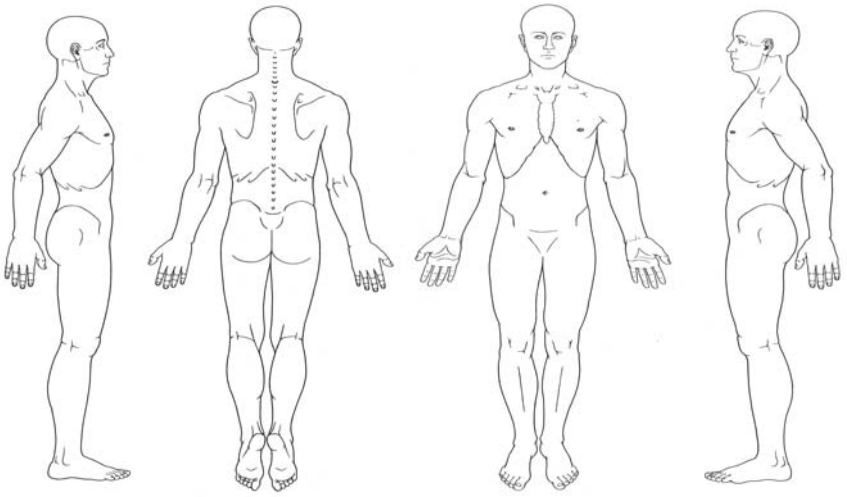
_____

_____

2. How often do you experience your symptoms?

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. How bad are your symptoms at their: *None* *Unbearable*

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

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

⓪	① ②	③ ④	⑤ ⑥	⑦ ⑧	⑨ ⑩
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?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

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:* _____

10. 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 Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. 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

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

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

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

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] *Feet Inches* Weight [ ][ ][ ] lbs.

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

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

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

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

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

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

COLLEYVILLE CHIROPRACTIC

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Colleyville Chiropractic's use and disclosure of my Protected Health Information **for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.** Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if Colleyville Chiropractic agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

COLLEYVILLE CHIROPRACTIC

Patient:_____ File #:_____

Consent to Chiropractic Services

Explanation of Risks

Manipulation is considered one of the safest methods available for the treatment of many spinal and joint disorders. Every reasonable precaution is taken to reduce the risk of adverse effects for this and any treatment. However, as with any health care procedure, there are certain complications which may arise during a manipulative adjustment. Those complications include but are not limited to: (1) Temporary aggravation of symptoms; (2) Other unlikely, but possible complications being stretch injuries to muscles, tendons and soft tissue, fracture or displacement of bones, disc injuries, injuries to nerves and occlusion of the blood vessels. Some types of manipulation of the neck have been associated with rate injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Please note the exact incidence of serious complication is described as rare or very rate.

I hereby consent to the performance of chiropractic procedures and diagnostics that the doctor of chiropractic may consider necessary or advisable in the course of my health care. I have read and understand the explanation of risks and I acknowledge that no guarantees have been made to me concerning the result of treatment.

_____ _____

Signature Date

Consent to Treatment of a minor child

I authorize the licensed chiropractor and whomever she may designate as assistants to administer

treatment to my _____(relationship), _____.

_____ _____

Signature of legal guardian Date