Patient Health Questionnaire

Patient Name _____ ***Date*** _____

1. ***Describe your symptoms:*** _____

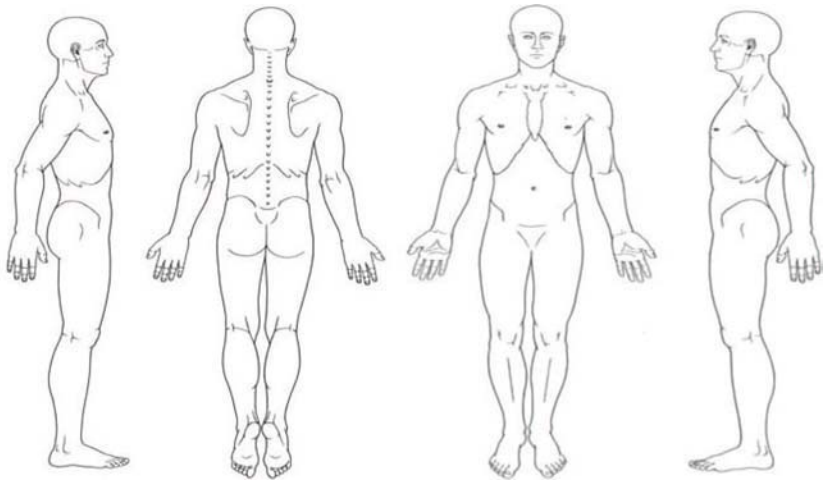
   _____

   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. ***Indicate current intensity of your symptions:***

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

6. ***Who else have you seen for your symptoms?***
   - ① No One ③ Medical Doctor ⑤ Other _____
   - ② Chiropractor ④ Physical Therapist

   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:* _____

7. ***Have you had similar symptoms in the past?*** ① Yes ② No

   If yes, when? _____

   a. If you have received treatment in the past for the same or similar symptoms, who did you see?
   - ① This Office ③ Medical Doctor ⑤ Other _____
   - ② Chiropractor ④ Physical Therapist

8. ***Have you had any previous injuries to the area of complaint (i.e. car accident, sports injuries, etc)?*** ① Yes ② No

   If yes, please list: _____

9. ***Have you tried any self treatment?*** ① Yes ② No

   a. Please indicate which self treatments were used.
   - ① Ice ④ Medications
   - ② Heat ⑤ Other _____
   - ③ Stretching

Patient Information

Date_____

First Name_____ Middle Initial_____ Last Name_____

Address _____ City _____ State_____ Zip_____

Telephone Number: Home_____ Cell_____Work_____

Email _____

*Your e-mail will not be shared with any 3rd parties and is used for occasional office announcements.

What is the best number to reach you? *Home* *Cell* *Work*

Age _____ Date of Birth _____

Current Occupation _____ *Full time* *Part time* *Retired* *Unemployed*

How did you hear about this office?_____

Emergency Contact/Guardian:

Name_____ Relationship_____ Phone_____

Health History

Current Medications:_____

_____

Do you have a permanent disability rating? ☐ Yes ☐ No

MEDICAL HISTORY: Please circle or note any health conditions that you may be experiencing now or have in the past.

Respiratory: emphysma, chronic cough, asthma, etc.
_____
_____

Cardiovascular: high blood pressure, aortic anuerysm, chest pains, heart attack, rapid heartbeat, etc._____
_____
_____

Gastrointestinal: IBS, heartburn, ulcers, etc._____
_____
_____

Other Conditions: diabetes, tumors, cancer, STDs, skin conditions, allergies, headaches, eating disorder, etc.
_____
_____

Musculoskeletal: joint pain, arthritis, sciatica, jaw pain, scoliosis, etc._____
_____

Neurological: strokes, concussions, numbness, tingling, dizziness, weakness, restless leg syndrome, etc.
_____
_____

Genitourinary: kidney stones, prostate problems, problems with urination, etc._____
_____

Other:
Abnormal weight loss or weight gain?_____
Number of pregnancies:_____
Do you use alcohol, drugs or tobacco?_____
If so, how much?_____

Please list any relevant or recent hospitalizations/surgical procedures:_____
_____

Have you seen a chiropractor before? If so, when was your last visit?_____

Family History

If a blood relative has had any of the following please indicate below.

Condition	Family Member	Condition	Family Member
Cancer		High Blood Pressure	
Heart Problems		Stroke	
Chronic Back Pain		Chronic Headaches	
Diabetes		Arthritis	

Text Message Agreement

Do you agree to receive text messages for appointment reminders? ☐ **Yes** ☐ **No**

Payment Policy and Informed Consent

Please check your selection

_____ Plan 1: Full payment at time of service with 15% discount. Cash, check, Visa and Mastercard are accepted.

_____ Plan 2: Third party liability case. Ex: Work comp or Auto Accident

_____ Plan 3: Billed insurance (Private Insurance, Medicare): Co-pays and deductibles are due at the time of service

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. If I have listed an insurance carrier, I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by Tanner Tryggestad I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are no guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

If a guardian is consenting for a minor and wishes to give the minor permission to attend visits by himself/herself, initial here. _____

Print Patient Name: _____ Print Guardian Name: _____

Patient or Guardian's Signature_____ Date_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information **(PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree wit how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The patient understands and agree to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosure have been made and request in writing any further restrictions on the use of their PHI. Out office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. Patients have the right to file a formal complaint with out privacy official about any possible violations of these policies and procedures. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician as the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Print Patient Name _____

Print Guardian Name_____ Relationship_____

Patient or
Guardian Signature_____ Date_____