Patient Health Questionnaire - PHQ 

ACN Group, Inc. - Form PHQ-202

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

### Patient Name

1. ***Describe your symptoms***
   1. *When did your symptoms start?*



* 1. *How did your symptoms begin?*

### 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)

### What describes the nature of your symptoms?

1. Sharp (4) Shooting
2. Dull ache (5) Burning
3. Numb (6) Tingling

### Mark where you have pain or other symptoms

*c. How much has pain interfered with your normal work (including both work outside the home, and housework)*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***4. How are your symptoms changing?***   1. Getting Better 2. Not Changing 3. Getting Worse |  | | | | | | | | |
| ***5. How intense is the pain?:*** | *None* |  |  |  |  |  |  |  | *Unbearable* |
| *a. Indicate the worst intensity of your symptoms* | (0) (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) (10) |
| *b. Indicate the best intensity of your symptoms* | **(0) (1)** | **(2)** | **(3)** | **(4)** | **(5)** | **(6)** | **(7)** | **(8)** | **(9) (10)** |

* 1. Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

### 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

### In general would you say your overall health right now is...

* 1. Excellent (2) Very Good (3) Good (4) Fair (5) Poor

### Who have you seen for your symptoms?

1. No One
2. Chiropractor
3. Medical Doctor
4. Physical Therapist
5. Other
   1. *What treatment did you receive and when?*
   2. *What tests have you had for your symptoms and when were they performed?*
6. Xrays *date:* (3) CT Scan *date:*
7. MRI *date:* (4) Other *date:*
8. ***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?*

### What is your occupation?

1. This Office
2. Chiropractor
3. Professional/Executive
4. White Collar/Secretarial
5. Tradesperson
6. Medical Doctor
7. Physical Therapist
8. Laborer
9. Homemaker
10. FT Student

(5) Other

1. Retired
2. 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 INTAKE FORM (Page 2)**

### Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

### What makes your problem(s) worse?

1. ***What makes your problem(s) better?***

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

1. ***What is your:* Height**

## Weight

**Age**

### What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

### 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

□ □ Headaches □ □ High Blood Pressure □ □ Diabetes

□ □ Neck Pain □ □ Heart Attack □ □ Excessive Thirst

□ □ Upper Back Pain □ □ Chest Pains □ □ Frequent Urination

□ □ Mid Back Pain □ □ Stroke □ □ Smoking/Tobacco Use

□ □ Low Back Pain □ □ Angina □ □ Drug/Alcohol Dependance

□ □ Shoulder Pain □ □ Kidney Stones □ □ Allergies

□ □ Elbow/Upper Arm Pain □ □ Kidney Disorders □ □ Depression

□ □ Wrist Pain □ □ Bladder Infection □ □ Systemic Lupus

□ □ Hand Pain □ □ Painful Urination □ □ Epilepsy

□ □ Hip Pain □ □ Loss of Bladder Control □ □ Dermatitis/Eczema/Rash

□ □ Upper Leg Pain □ □ Prostate Problems □ □ HIV/AIDS

□ □ Knee Pain □ □ Abnormal Weight Gain/Loss □ □ Visual Disturbances

□ □ Ankle/Foot Pain □ □ Loss of Appetite □ □ Dizziness

□ □ Jaw Pain □ □ Abdominal Pain □ □ Asthma

□ □ Joint Pain/Stiffness □ □ Ulcer □ □ Chronic Sinusitis

□ □ Arthritis □ □ Hepatitis **For Females Only**

□ □ Rheumatoid Arthritis □ □ Liver/Gall Bladder Disorder □ □ Birth Control Pills

□ □ Cancer □ □ General Fatigue □ □ Hormonal Replacement

□ □ Tumor □ □ Muscular Incoordination □ □ Pregnancy

* □ Other:

1. ***List all medications you are currently taking: (if many medications, use Certification form instead)***

### List all of the nutritional supplements you are currently taking:

1. ***List all surgical procedures you have had (with date, if known):***

### What activities do you do at work?

□ **Sit:** □ Most of the day □ Half the day □ A little of the day

□ **Stand:** □ Most of the day □ Half the day □ A little of the day

□ **Computer work:** □ Most of the day □ Half the day □ A little of the day

□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

### What activities do you do outside of work?

1. ***Have you ever been hospitalized?*** □ No □ Yes

if yes, why

1. ***Have you had significant past trauma?*** □ No □ Yes (if so, please elaborate in side margin)

### Anything else pertinent to your visit today?

***Patient Signature Date:***

**PATIENT FINANCIAL INFORMATION:** please print TODAY’S DATE

NAME: SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP:

**CELL PHONE:** ( )

HOME PHONE: DATE OF BIRTH:

Cell Phone Carrier (for texting appointment reminders)

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

OCCUPATION: WORK PHONE: ( ) EXT:

EMPLOYER:

SPOUSE’S NAME:

REFERRED TO OUR OFFICE BY: RELATIONSHIP:

# PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME: RELATIONSHIP:

ADDRESS: PHONE: ( )

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

( ) HEALTH INSURANCE: NAME OF INSURANCE COMPANY:

NAME OF INSURED: INSURED’S ID NUMBER:

CHOOSE ONE

( ) AUTO INSURANCE (fill out auto accident form)

( ) WORKMAN’S COMPENSATION INSURANCE (fill out work comp form) ( ) CASH AT TIME OF SERVICE

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:

**PLEASE READ AND SIGN BACK**

Patients Name Today’s Date

Office Initials

**CONSENT FORM**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) by the Doctor of Chiropractic Jeffrey Eaton, and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I understand I will have an opportunity to discuss with Dr. Eaton and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not 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 or her, 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.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian’s Print\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent or Guardian’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AGREEMENT**

1. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

2. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me.

3. I understand that whatever amount you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you.

4. Should my insurance company deny benefits, for any reason, I accept responsibility for payment of any services rendered.

5. I waive any applicable Statute of Limitations which may at any time interfere with your right to collect for services rendered to me.

6. I do not knowingly submit insurance information that is incorrect and/or invalid.

7. Should my insurance company send me a check/draft (for services rendered to me), I understand that it is my responsibility to immediately give it to you. I will not cash or deposit said check/draft to a bank account.

8. I give assignment and lien against any claims against a third party whose negligence may have caused the patient’s injury, up to the amount of the bill for treatment and including interest, attorney and court fees.

9. I understand that any balance that is not paid within 90 days will be considered “Past Due,” may be subject to a late fee of up to $10, and must be paid in full before I will be allowed to schedule any future appointments.

10. I understand that all self-pay charges and insurance co-pays are due at time of service.

11. If I need to cancel or reschedule my appointment, I agree to call at least 1 hour prior to my scheduled appointment. After missing 3 appointments without calling, I understand I may be charged a “No-show” fee of $20.

12. In the event that any section or provision of this Agreement is legally void, invalid, or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian’s Print\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent or Guardian’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_