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 _____

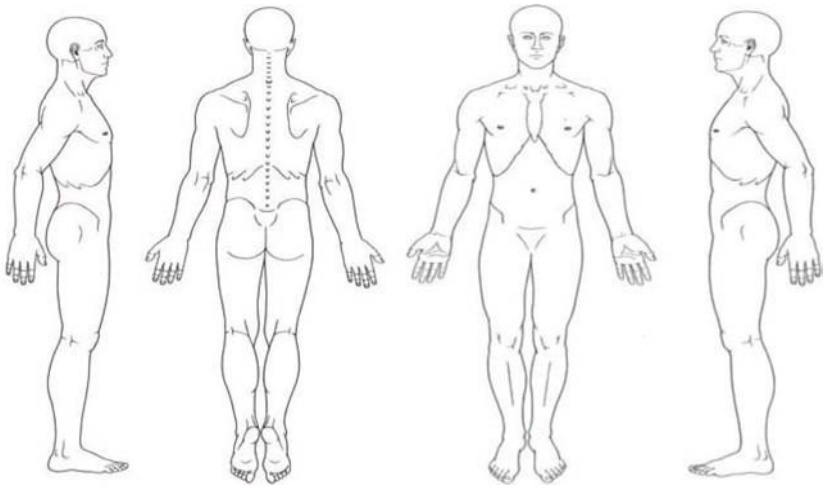
a. When did your symptoms start? _____

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)

Mark 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 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)

c. 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. 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

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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 INTAKE FORM (Page 2)

11. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

12. What makes your problem(s) worse?

_____

13. What makes your problem(s) better?

_____

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

_____

15. What is your: **Height**_____ **Weight** _____ **Age** _____

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
□	□ 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:_____				

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

_____

20. List all of the nutritional supplements you are currently taking:

_____

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

_____

22. 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

23. What activities do you do outside of work?

_____

24. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

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

26. 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)

CHOOSE ONE

( ) 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

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

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 below, for whom I am legally responsible) by the doctor of chiropractic named below 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 have had an opportunity to discuss with the doctor of chiropractic named below 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.

Patient Signature_____ Date _____

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 waiver 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. 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'S SIGNATURE PARENT OR GUARDIAN'S SIGNATURE

Certification Information

Dear Patient: The US government is now requiring that we supply them with the following information

Patient Demographics:

Staff: *(To be entered in E-Z Notes through "Edit Patient Info")*

Name: (Print clearly) _____ **Today's Date:** _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other_____

If the Government needs to contact you, how would you like this confidential communication to be received? (circle one option)

- Call phone: (HOME/CELL/OFFICE)
- Text phone
- E-Mail
- Mailing Address

Blood Pressure: _____/_____ **Height:** _____ **Weight:** _____

Smoking Status:	Smokes every day	Smokes some days	Former Smoker	Never Smoked

Prescribed Medicines

Staff: *(Enter in E-Z Notes through: Edit Patient Info >Edit /View Patient's Data>Prescriptions/Allergies)*

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued?**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:

Check here if you do not have any medicinal allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache

Have you been diagnosed with: (Please circle)

Asthma?	Diabetes?