

# Primary Care Chiropractic Center, Inc.

NAME \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial) (Age) (Date of Birth)

ADDRESS \_\_\_\_\_  
(Street) (Apt. #) Single \_\_\_\_\_ Separated \_\_\_\_\_  
Married \_\_\_\_\_ Divorced \_\_\_\_\_  
(City) (State) (Zip Code) Widowed \_\_\_\_\_ # Children \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_  
(A/C) (A/C)

YOUR OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

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

SPOUSE'S SOCIAL SECURITY NO \_\_\_\_\_ SPOUSE'S WORK PHONE (\_\_\_\_\_) \_\_\_\_\_  
(A/C)

SPOUSE'S DATE OF BIRTH \_\_\_\_\_ RESPONSIBLE PARTY (if patient is a minor) \_\_\_\_\_

REFERRED BY \_\_\_\_\_

EMERGENCY CONTACT (at a different address) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_  
(A/C)

ADDRESS \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

WE APPRECIATE PAYMENT AT THE TIME OF SERVICE

PLEASE NOTE: **Primary Care Chiro. Center** does not participate with nor accept assignment on TennCare or Champus.

## INSURANCE INFORMATION

**As a courtesy to you, we will be happy to file your insurance for your treatment with an assignment of benefits. Payment for services rendered to you, however, are ultimately the responsibility of you, the patient, and not contingent upon insurance settlement. Please furnish the information below.**

Patient's Insurance \_\_\_\_\_ Spouse's Insurance \_\_\_\_\_

Mailing Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

Policy (SS #) \_\_\_\_\_ Group # \_\_\_\_\_ Policy (SS #) \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_\_ Effective Date \_\_\_\_\_

Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Is this through your employer? \_\_\_\_\_ Is this through your employer? \_\_\_\_\_

I accept personal responsibility for payment of the charges for services rendered to me. I authorized payment of medical insurance benefits to **Primary Care Chiro. Center** and authorize the release of any medical information that may be necessary to process the claim. I will be responsible for the fee in excess of my insurance reasonable and customary. I also understand that I am responsible for any expense that may be incurred in collecting this account, plus court costs and reasonable attorney fees, should such action become necessary.

Date \_\_\_\_\_

Signature \_\_\_\_\_

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group Use Only rev 9/11/2002

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

## 1. Describe your symptoms

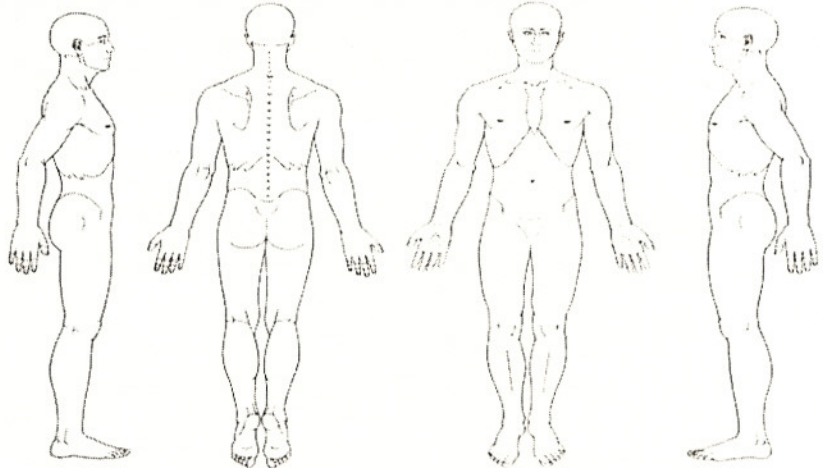
\_\_\_\_\_  
\_\_\_\_\_

a. When did your symptoms start? \_\_\_\_\_

b. How did your symptoms begin? \_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other 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)



## 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 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable ⑩

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 Other 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: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

- ① Yes
- ② No
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

## 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 Health Questionnaire - page 2**

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 

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      Weight 

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 lbs.

Feet      Inches

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"/> Headaches                | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> Neck Pain                | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Excessive Thirst             |
| <input type="checkbox"/> Upper Back Pain          | <input type="checkbox"/> Chest Pains                 | <input type="checkbox"/> Frequent Urination           |
| <input type="checkbox"/> Mid Back Pain            | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Smoking/Use Tobacco Products |
| <input type="checkbox"/> Low Back Pain            | <input type="checkbox"/> Angina                      | <input type="checkbox"/> Drug/Alcohol Dependence      |
| <input type="checkbox"/> Shoulder Pain            | <input type="checkbox"/> Kidney Stones               | <input type="checkbox"/> Allergies                    |
| <input type="checkbox"/> Elbow/Upper Arm Pain     | <input type="checkbox"/> Kidney Disorders            | <input type="checkbox"/> Depression                   |
| <input type="checkbox"/> Wrist Pain               | <input type="checkbox"/> Bladder Infection           | <input type="checkbox"/> Systemic Lupus               |
| <input type="checkbox"/> Hand Pain                | <input type="checkbox"/> Painful Urination           | <input type="checkbox"/> Epilepsy                     |
| <input type="checkbox"/> Hip/Upper Leg Pain       | <input type="checkbox"/> Loss of Bladder Control     | <input type="checkbox"/> Dermatitis/Eczema/Rash       |
| <input type="checkbox"/> Knee/Lower Leg Pain      | <input type="checkbox"/> Prostate Problems           | <input type="checkbox"/> HIV/AIDS                     |
| <input type="checkbox"/> Ankle/Foot Pain          | <input type="checkbox"/> Abnormal Weight Gain/Loss   |   |
| <input type="checkbox"/> Jaw Pain                 | <input type="checkbox"/> Loss of Appetite            | <b>Females Only</b>                                   |
| <input type="checkbox"/> Joint Swelling/Stiffness | <input type="checkbox"/> Abdominal Pain              | <input type="checkbox"/> Birth Control Pills          |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Ulcer                       | <input type="checkbox"/> Hormonal Replacement         |
| <input type="checkbox"/> Rheumatoid Arthritis     | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Pregnancy                    |
|   | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/>                              |
| <input type="checkbox"/> General Fatigue          | <input type="checkbox"/> Cancer                      | <b>Other Health Problems/Issues</b>                   |
| <input type="checkbox"/> Muscular Incoordination  | <input type="checkbox"/> Tumor                       | <input type="checkbox"/>                              |
| <input type="checkbox"/> Visual Disturbances      | <input type="checkbox"/> Asthma                      | <input type="checkbox"/>                              |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Chronic Sinusitis           | <input type="checkbox"/>                              |

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:

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

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

Doctor's Additional Comments

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Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_