New Patient Intake Form

Welcome to our chiropractic office. We want to provide you with the best possible care. We base our care on a thorough history and examination. Thank you for taking the time to fill in our ***Patient Intake Form***. Please fill this form out as most complete as you can and to the best of your knowledge. Let our staff know if you have any questions. When completed return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Patient Name:________________________ DOB:__________ Sex: M / F

Preferred Language:______________ Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Race: American Indian or Alaska Native/ Asian/ Black or African American / White (Caucasian) / Native Hawaiian / Other / I Decline to Answer

Address: ________________________ Email: ________________________

________________________ Cell/Home #: ________________________

Emergency Contact: Name/Number: ________________ How did you hear about our office? ____________

Insurance Information

Insured Information (If different than above)

Name of Insured: ________________ Date of Birth: ____________

Address: ________________________ City:________ State: ________ Zip: ________

Your relationship to Insured: ____________ Employer: ____________

Personal History

List current medication:____

(name, amounts, frequency, length of use, reason for use)

List any medication allergies:________________________________

(please include reaction and date of onset)

Brief Explanation:

Hospitalizations/ Surgeries: ________________________________

Past Major Illness:____

Other Accidents/Incidents:____________________________________

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

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

Patient Name ______________________ ***Date*** ______________________

1. Describe your symptoms ______________________

____

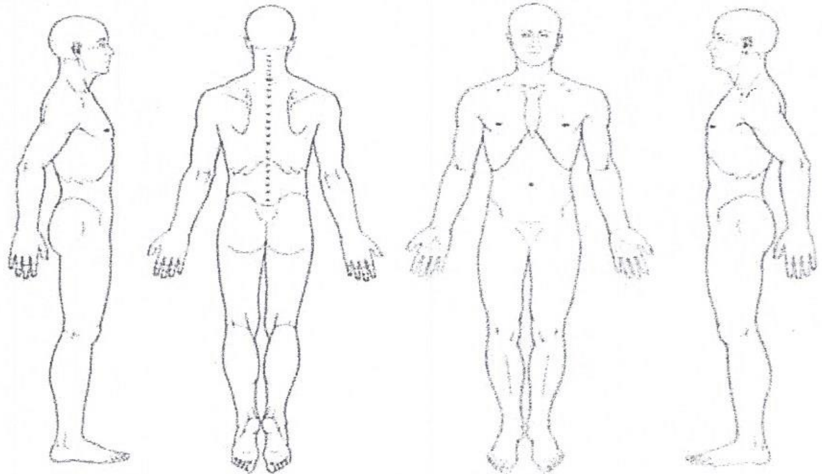
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

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

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ 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)

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

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

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. Who have you seen for your symptoms?

☐ No One ☐ Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* ________ ☐ CT Scan *date:* ________
☐ MRI *date:* ________ ☐ Other *date:* ________

9. Have you had similar symptoms in the past? ☐ Yes ☐ No

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

☐ This Office ☐ Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

10. What is your occupation?

☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker ☐ FT Student ☐ Retired ☐ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other

Physican Signature ______________________ ***Date*** ______________________

Patient Name:______________________________ Date:____________

The following information may be contributing to/complicating your current condition so please answer to the best of your ability:

Circle All That Apply

Social History

On average I consume:

A. Caffeine: Daily .. Occasionally .. Never
B. Alcohol: Daily .. Occasionally .. Former .. Never
C. Tobacco: Daily .. Occasionally .. Former .. Never

Review of Systems:

I have had or been told I have:

A. Epilepsy, Convulsions, Paralysis, Dementia, Alzheimer's, Migraine/Headaches or other disorders of the brain/nervous system.
B. Chest pain, Heart attack, Heart murmur, High/Low blood pressure, Palpitation, Stroke or other disorders of the circulatory system.
C. Asthma, Emphysema, Tuberculosis, Sleep apnea or other disorders of the respiratory system.
D. Allergies, Itching, Wheezing, Tonsillitis, Nose bleeds, Difficulty swallowing, Earaches, Sinusitis, Deafness, Double vision or other disorders of the eyes/ears/nose/throat.
E. Ulcer, Intestinal bleeding, Colitis, Constipation, Diarrhea, Hernia, Hepatitis or other disorders of the intestines/liver/pancreas/spleen.
F. Painful urination, Blood in urine, Increase/Decrease urination, Kidney stones, Nephritis, or other disorders of the bladder/kidneys.
G. Diabetes, Thyroid dysfunction or other glandular disorders.
H. Arthritis, Gout or other muscle/joint disorders.
I. Depression, Anxiety or other mental/emotional disorders.
J. Cancer, Tumor or Lymph node enlargement.
K. Physical deformity or defect.
L. Any conditions/symptoms/disorders not listed above that you would like the doctor to know?

Family History

Do you have parents, siblings or children that have been diagnosed with:

Cancer .. Diabetes .. Hypertension .. Heart Problems .. Kidney Problems .. Arthritis .. Osteoporosis .. Headache/Migraine .. Autoimmune Disorders

Humboldt Spine
and Rehab P.C.
702 13th St. N.
Humboldt IA 50548
(515) 332-7990

Patient Name: ______________________________ **Date:** ______________________

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Humboldt Spine & Rehab, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Office Policy:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit. If the account balance exceeds $150, services may be withheld.

Consent to Evaluate and Treat a Minor:

I, ______________________________ being the parent or legal guardian of ______________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: ____

Children: ____

Others: ____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: ____

Signature: ______________________________________ Date: ________________________