NEW PATIENT INFORMATION FORM

Our File # _____

PATIENT DATA

Name _____ Today's Date _____

( ) Male ( ) Female What do you prefer to be called? _____

Age _____ Date of Birth _____ Social Security No. _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Other Phone _____

E-Mail _____

(Your e-mail will NOT be shared with any third parties and is used only for occasional office announcements and promotions.)

Employer _____ For How Long? _____

Employer's Address _____

Marital Status: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Spouse's Name _____ Number of Children _____ Ages of Children _____

Emergency Contact _____ Phone _____

Name of family medical doctor _____ Phone _____

Have you ever been treated by a chiropractor before? ( ) Yes ( ) No If yes, whom and when? _____

Who should we thank for referring you to our office? _____

HEALTH HISTORY

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

( ) Nerve Pills ( ) Pain Killers - including aspirin ( ) Muscle Relaxers ( ) Stimulants

( ) Blood Thinners ( ) Tranquilizers ( ) Insulin ( ) Other(s) _____

Do you take supplements, vitamins, minerals or herbs? ( ) Yes ( ) No

If yes, please list dosage and frequency _____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

( ) Heart Attack/Stroke
( ) Congenital Heart Defect
( ) Alcohol/Drug Abuse
( ) HIV+/Aids
( ) Frequent Neck Pain
( ) High/Low Blood Pressure
( ) Severe/Frequent Headaches
( ) Fainting/Seizures/Epilepsy
( ) Diabetes
( ) Lower Back Problems

( ) Heart Surgery/Pacemaker
( ) Mitral Valve Prolapse
( ) Venereal Disease
( ) Shingles
( ) Emphysema/Glaucoma
( ) Psychiatric Problems
( ) Kidney Problems
( ) Sinus Problems
( ) Difficulty Breathing
( ) Artificial Bones/Joints

( ) Heart Murmur
( ) Artificial Valves
( ) Hepatitis
( ) Cancer/Chemotherapy
( ) Anemia
( ) Rheumatic Fever
( ) Ulcers/Colitis
( ) Asthma
( ) Tuberculosis
( ) Arthritis

Please describe any other serious medical condition(s) you have or ever have had: _____

_____

Have you ever had any sprains/strains/broken bones/joint injuries? ( ) Yes ( ) No If yes, please explain _____

_____

Have you ever had cancer? ( ) Yes ( ) No If yes, what type and how long ago were you diagnosed? _____

Have you ever been hospitalized or had surgery? ( ) Yes ( ) No If yes, please explain _____

Have you ever been in an auto accident? ( ) Yes ( ) No If yes, please explain _____

Have you ever been struck unconscious? ( ) Yes ( ) No If yes, please explain _____

Are you allergic to anything? ( ) Yes ( ) No If yes, please explain _____

Are you on a special diet? ( ) Yes ( ) No If yes, please explain _____

Do you smoke? ( ) Yes ( ) No If yes, how much and for how long? _____

Do you drink alcohol? ( ) Yes ( ) No If yes, how many drinks per week? _____ Type? ( ) Beer ( ) Wine ( ) Liquor

Are you wearing ( ) Heel Lifts ( ) Sole Lifts ( ) Inner Soles ( ) Arch Supports

What is the age of your mattress? _____ Is it comfortable? ( ) Yes ( ) No

What is the date of your last physical exam? _____

Past and present health conditions of family members (heart disease, diabetes, arthritis, etc.)

_____

_____

For Women Only: Are you taking birth control? ( ) Yes ( ) No Are you nursing? ( ) Yes ( ) No

Is there a chance that you are pregnant? ( ) Yes ( ) No If yes, how far along are you? _____

INSURANCE/ACCOUNT INFORMATION

Will we be helping you file insurance? ( ) Yes ( ) No

Name of insurance company _____ Insurance No. _____

Name of Insured _____ Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Other Phone _____

Insured's Social Security No. _____ Insured's Date of Birth _____

AUTHORIZATION AND RELEASE

I authorize assignment of my insurance rights and benefits directly to the provider for services rendered and authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize Northridge Chiropractic to release all information necessary to communicate with personal physicians and other healthcare providers and payors to secure the payment of the benefits. I understand and agree that health/accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for all costs of care, regardless of insurance coverage. I also understand that payment of services is due at the time of service unless other financial arrangements have been made. I further understand and agree that if I suspend or terminate my schedule of care/treatment, any fees for professional services rendered to me will be immediately due and payable. I agree, in the event of non-payment, to bear the cost of collection, including court costs and legal fees should this be required. I authorize Northridge Chiropractic to perform any necessary services needed during diagnosis and treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature _____ Date _____

( ) Adult Patient ( ) Parent or Guardian ( ) Spouse

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ *Date* _____

1. Describe your symptoms _____

_____

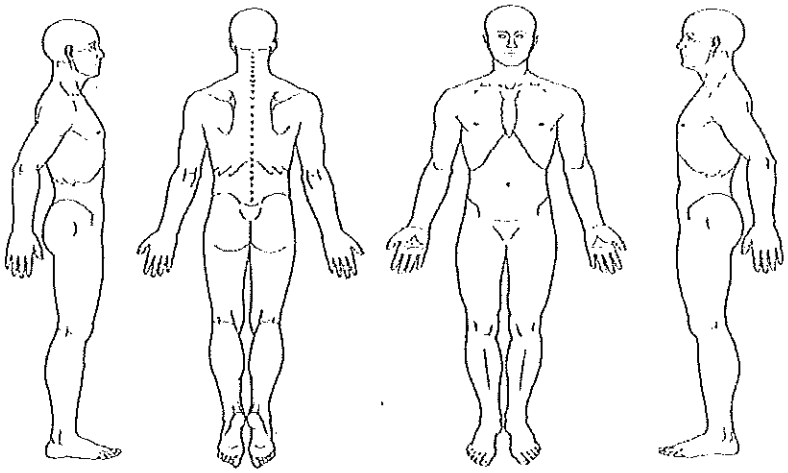
a. When did your symptoms start? _____

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. During the <u>past 4 weeks</u>:

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)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> 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 ③ Medical Doctor ⑤ Other
② Other 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:* _____

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 ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

10. What is your occupation?

_____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

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

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient 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 health care operations we must require you to read and sign this consent form stating that you understand and agree with 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 Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (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.
2. 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 disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect 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.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. 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.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

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

_____ _____

Name of Patient Date

For further information regarding this notice, please contact our Doctor at (765)362-0123

Northridge CHIROPRACTIC ACUPUNCTURE

2206 Lafayette Road
Crawfordsville, IN 47933

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:** _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (circle one):** Male / Female **Preferred Language:** _____

Smoking Status (circle one) : Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (optional): _____ **Are you interested in smoking cessation (circle one):** Yes / No

Family Medical History *(record one diagnosis in your family history and the affected relative)*				
Diagnosis (write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

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

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

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