Welcome to Edmistone Acupuncture and Chiropractic

PATIENT INFORMATION

_____ _____ _____ M / F
Last Name First Name Middle Initial Gender

_____ / _____ / _____ _____ Single - Married - Other _____ - _____ - _____
Date of Birth Age Marital Status (circle one) Social Security #

_____ _____ _____ _____
Street Address City State Zip

(_____) _____ - _____ (_____) _____ - _____ _____
Home Phone Cell Phone Email Address

_____ _____ (_____) _____ - _____
Emergency Contact Relationship Phone #

INSURANCE INFORMATION

_____ _____ _____ (_____) _____ - _____
Primary Insurance Group/Policy # ID# Customer Service Phone #

_____ _____ _____ (_____) _____ - _____
Secondary Insurance Group/Policy # ID# Customer Service Phone #

Insured Information: (Must be completed if the patient is not the insured member.)

_____ _____ _____
Last Name First Name MI

_____ / _____ / _____ _____ _____ - _____ - _____
Date of Birth Age Social Security #

_____ _____ _____ _____
Street Address City State Zip

Relationship to patient _____ Employer_____

REFERRAL INFORMATION

How did you hear about our office? _____

Authorization and Assignment Notice

a. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. b. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services. c. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for you services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under “Pertinent Data”) and authorize you to prosecute said action in my name as you see fit. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe to your office. d. I further agree that this Authorization and Assignment is irrevocable until all monies owed to Edmistone Chiropractic are paid in full.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature Date

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 _____

_____

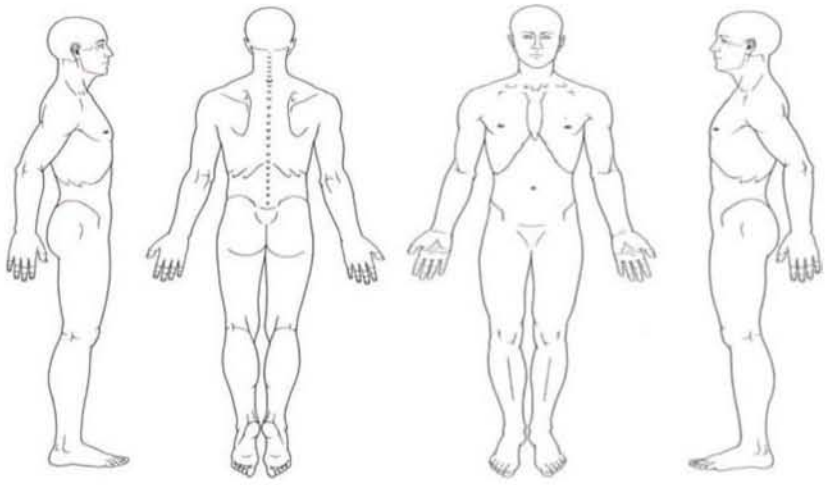
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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 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)

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

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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 Signature _____ **Date** _____

Name _____ Phone ( ) _____ - _____
Birthdate _____ /____ /_____ age _____ height _____ weight _____

Complaint/How Long?
_____
_____

Have you received Treatment?
_____
_____

List All Surgeries / Trauma with dates
_____
_____

List All Medications / Allergies
_____
_____

Please Check All of the Following that Apply

FAMILY MEDICAL HISTORY

○ Obesity	○ Seizures	○ Diabetes	○ Cancer _____
○ Stroke	○ High blood pres.	○ Heart Disease	○ Other_____

YOUR HABBITS

○ Cigarettes per day ____	○ Street drugs	○ Tea	○ Artificial sweetener
○ Smoke other per day ____	○ Coffee	○ Chocolate	○ Salt
○ Alcohol per week ____	○ Cola/Soda	○ Sugar	

Explain any cravings_____

GENERAL

○ Poor appetite	○ Tremors	○ Fevers	○ Poor coordination
○ Heavy appetite	○ Vertigo	○ Chills	○ Change in appetite
○ Poor sleep	○ Cold hands	○ Night sweats	○ Energy loss
○ Heavy sleep	○ Cold feet	○ Sweat easily	○ Peculiar taste/smell
○ Insomnia	○ Cold back	○ Cravings	○ Bleed or bruise easily
○ Fatigue	○ Cold abdomen	○ Localized weakness	

SKIN/HAIR

○ Rashes	○ Itching	○ Dandruff	○ Change in texture Hair/Skin
○ Ulcerations	○ Eczema	○ Hair loss	
○ Hives	○ Pimples		○ Other

HEAD, EYES, EARS, NOSE, AND THROAT

○ Dizziness	○ Concussions	○ Poor vision	○ Ear aches
○ Eye strain	○ Eye pain	○ Blurry vision	○ Sinus problems
○ Color blindness	○ Cataracts	○ Nose bleeds	○ Copious saliva
○ Ringing in ears	○ Poor hearing	○ Dry mouth	○ Facial Pain
○ Mucus	○ Dry throat	○ Grinding teeth	
○ Teeth problems	○ Jaw clicks	○ Glasses	
○ Mouth Sores	○ Migraines	○ Night blindness	
○ Headaches (explain)		○ Other Head or Neck problems	

_____ _____

CARDIOVASCULAR

- ○ High blood pressure
- ○ Low blood pressure
- ○ Chest Pain
- ○ Irregular heartbeat
- ○ Dizziness
- ○ Fainting
- ○ Cold hands/feet
- ○ Swelling in hands/feet
- ○ Blood clots
- ○ Phlebitis
- ○ Difficulty breathing
- ○ Other _____

RESPIRATORY

- ○ Cough
- ○ Production of phlegm
- ○ Asthma
- ○ Tight chest
- ○ Pneumonia
- ○ Coughing blood
- ○ Bronchitis
- ○ Difficulty breathing when lying down

GASTROINTENTINAL

- ○ Nausea
- ○ Constipation
- ○ Rectal pain
- ○ Black stool
- ○ Gas
- ○ Vomiting
- ○ Bloody stools
- ○ Hemorrhoids
- ○ Bad breath
- ○ Belching
- ○ Diarrhea
- ○ Sensitive abdomen
- ○ Bowel Movement: Freq._____ Color _____ Odor _____

GENITO-URINARY

- ○ Pain on urination
- ○ Wake up to urinate
- ○ Blood in urine
- ○ Impotency
- ○ Unable to hold urine
- ○ Frequent Urination
- ○ Venereal disease
- ○ Kidney stones
- ○ Urgency to urinate
- ○ Other _____

PREGNANCY AND GYNECOLOGY

- ○ Number of pregnancies
- ○ Vaginal discharge
- ○ Vaginal sores
- ○ Breast lumps
- ○ Age at first menses
- ○ Number of births
- ○ Premature births
- ○ Miscarriages
- ○ Clots
- ○ Period duration
- ○ Duration of last period
- ○ Irregular Period
- ○ Date of last PAP test _____
- ○ Date of last period _____

MUSCULOSKELTAL

- ○ Neck pain
- ○ Muscle pain
- ○ Back pain
- ○ Joint pain

Explain_____

_____

NEUROPSYCHOLOGICAL

- ○ Seizures
- ○ Anxiety
- ○ Concussion
- ○ Treated for emotional problems
- ○ Depression
- ○ Poor memory
- ○ Easily stressed
- ○ Areas of numbness
- ○ Bad temper

OTHER _____

_____

_____

_____ _____

Patient Signature Date

Edmistone Acupuncture & Chiropractic RECEIPT OF PRIVACY NOTICE

Patient name _____

Date of Birth _____ /_____/_____

Phone Number _____

My signature below certifies that I have reviewed a copy of the Notice of privacy Practices.

_____
Signature of Patient or Guardian

_____
Date