

PATIENT INTRODUCTION

Name _____ MI _____ Birthdate ____ / ____ / ____

Address _____ City _____ State _____ Zip _____

Phone(H) _____ (W) _____ (Cell) _____

Social Security _____ Sex M / F Marital Status S / M / D / W

Employer _____ E-Mail _____

Names of Children _____ Referred By _____

Spouse/Parents Name _____ Insured's Employer _____

Emergency Contact _____ Relationship _____

Address _____ Phone _____

OFFICE POLICY FOR CASH ACCOUNTS

Patients that are not covered by any insurance and are treated under a cash account will be expected to pay for their treatment, nutritional supplements, pillows, braces, and belts the day that it is received. If this is not possible you must make prior arrangements with our office.

You will receive a statement if there is an outstanding balance and interest will be charged on all past due balances.

Please make all checks payable to: **Cold Spring Chiropractic**

I hereby authorize Cold Spring Chiropractic to release any information necessary to process any and all claims. Assign benefits payable directly to the above clinic.

I hereby authorize Cold Spring Chiropractic to treat me for any and all conditions.

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Doctors at Cold Spring Chiropractic to administer chiropractic care as he/she deems necessary to my son/daughter.



Patient, Parent, or Guardian Signature

Date

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102



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

Patient Name _____

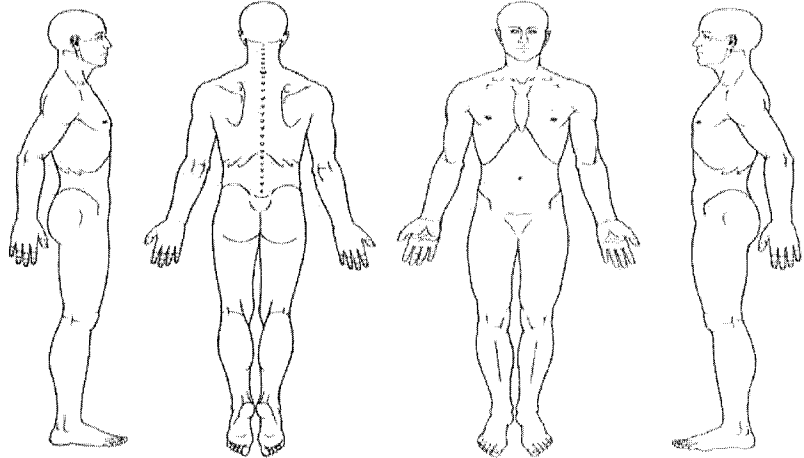
Date _____

1. When did your symptoms start: _____

Describe your symptoms and how they began:

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. How bad are your symptoms at their:

- None Unbearable
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints ② Mild, forgotten with activity ③ Moderate, interferes with activity ④ Limiting, prevents full activity ⑤ Intense, preoccupied with seeking relief ⑥ Severe, no activity possible

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

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

a. When and what treatment? _____

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: _____

10. 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 Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. 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

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

Patient Signature _____

Date _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

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

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

| | | |
|--|--|--|
| | | |
|--|--|--|

Weight

| | | |
|--|--|--|
| | | |
|--|--|--|

 lbs.

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

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain

- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain

- Hip/Upper Leg Pain
- Knee/Lower Leg Pain
- Ankle/Foot Pain

- Jaw Pain

- Joint Swelling/Stiffness
- Arthritis
- Rheumatoid Arthritis

- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Angina

- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems

- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder

- Cancer
- Tumor

- Asthma
- Chronic Sinusitis

Past Present

- Diabetes
- Excessive Thirst
- Frequent Urination

- Smoking/Use Tobacco Products
- Drug/Alcohol Dependence

- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/AIDS

Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy
-

Other Health Problems/Issues

-
-
-

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:

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

Patient Signature _____ Date _____

Doctor's Additional Comments

Doctors Signature _____ Date _____

Cold Spring Chiropractic

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Cold Spring Chiropractic we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including any of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as

possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
Gayle Kinzer, Privacy Officer

If you would like further information about our privacy policies and practices please contact:

Gayle Kinzer, Privacy Officer

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please)

Signature

Date

If you are a minor, or if you are being represented by another party

Personal Representative (Printed)

Personal Representative Signature

Date

Description of the authority to act on behalf of the patient.