CONFIDENTIAL PATIENT HISTORY

NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE ( ) _____ WORK PHONE ( ) _____

OCCUPATION_____

EMPLOYER_____

EMPLOYER'S ADDRESS_____

EMPLOYER'S PHONE (____) _____NAME OF CONTACT_____

SOCIAL SECURITY NUMBER _____-___-_____ BIRTHDATE_____

MARITAL STATUS S M D W
SPOUSE'S NAME_____
SPOUSE'S SOCIAL SECURITY #_____-___-_____ NUMBER OF CHILDREN_____
SPOUSE'S EMPLOYER AND PHONE_____

REFERRED TO THIS CLINIC BY: _____

INSURANCE

Primary Insurance

Medica	Preferred One
Medical Assistance	Blue Cross Blue Shield
Worker's Compensation	Personal Injury
Medicare	Other_____

Have you had x-rays taken on your neck, middle back or lower back in the past 3 years?
_____YES _____NO If yes, at which clinic?_____

Secondary Insurance
Please list, if any_____

Emergency Contact Name_____

Emergency Physician_____

PATIENT SIGNATURE_____Date_____
Thank you for your cooperation in helping us to keep our records current.
Annandale Family and Sports Chiropractic 5/07

ANNANDALE FAMILY & SPORTS CHIROPRACTIC
INFORMED CONSENT FORM

As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to specifically explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments.

Appropriate tests and history will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.

In signing this document, I in no way compromise my protection against negligence.

I have read and understand the above statement and hereby consent to treatment.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Patient Health Questionnaire - PHQ

ChiroCare Form PHQ-202

ChiroCare Use Only rev 5/27/2003

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

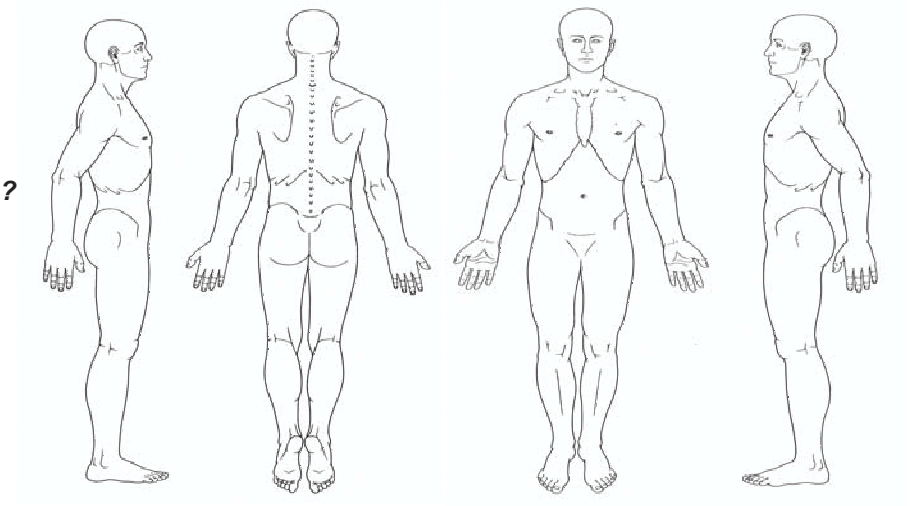
a. When did your symptoms start? _____

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
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:* _____ 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 Other 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*** _____

Patient Health Questionnaire – page 2

version 1.18.13

Patient name_____ **Date** _____

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	
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	Muscular incoordination
○	○	Visual disturbances
○	○	Dizziness
○	○	High blood pressure
○	○	Heart attack
○	○	Stroke
○	○	Systemic lupus
○	○	HIV/AIDS
○	○	Allergies
○	○	Shoulder pain

Past	Present	
○	○	Angina
○	○	Kidney stones
○	○	Kidney disorder
○	○	Bladder infection
○	○	Prostate problems
○	○	Loss of appetite
○	○	Ulcer
○	○	Asthma
○	○	Epilepsy
○	○	Drug/alcohol dependence
○	○	Depression
○	○	Dermatitis/eczema/rash

Past	Present	
○	○	Chronic sinusitis
○	○	Diabetes
○	○	Excessive thirst
○	○	Frequent urination
○	○	Smoking/tobacco use
Females only		
○	○	Pregnancy
○	○	Hormone replacement
○	○	Birth control pills
Other health issues		
○	○	
○	○	

For each of the symptoms listed below, place a check in the present column if you are currently experiencing this symptom.

Present		
○		Cough
○		Coughing blood
○		Wheezing
○		Chills
○		Heart murmur
○		Chest pain
○		Fainting spells
○		Dizziness
○		Shortness of breath
○		Difficulty laying flat
○		Swelling of the ankles
○		Heartburn/reflux
○		Nausea/vomiting
○		Constipation
○		Changes in bowel movements
○		Diarrhea
○		Jaundice
○		Abdominal pain
○		Black/bloody bowel movements
○		urinary burning/frequency
○		urinary nighttime urgency

Present		
○		Blood in urine
○		Erectile dysfunction
○		Abnormal urinary discharge
○		Bladder leakage
○		Loss of strength
○		Numbness
○		Headaches
○		Heavy head
○		Tremors
○		Memory loss
○		Joint pain/swelling
○		Stiffness
○		Muscle pain
○		Neck pain
○		Stiff neck
○		Back pain
○		Bruise easily
○		Gums bleed easily
○		Enlarged glands
○		Unusual weight loss/gain
○		Fatigue

Present		
○		Fever
○		Difficulty hearing
○		Buzzing in ears
○		Ringing in ears
○		Vertigo
○		Sinus trouble
○		Nasal stuffiness
○		Frequent sore throat
○		Loss of hair
○		Heat/cold intolerance
○		Glasses/contacts
○		Eye pain
○		Light-sensitive
○		Double vision
○		Cataracts
○		Anxiety/depression
○		Mood swings
○		Difficulty sleeping
○		Nervousness
○		Tension
○		Skin Rashes/sores/itching

Please indicate if an immediate family member has had any of the following:

○ Heart disease ○ Diabetes ○ Cancer ○ Lupus ○ Rheumatoid Arthritis ○ Back/Neck pain

List all prescription and over-the-counter medications, and nutritional supplements you are taking currently:

_____

_____

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

_____

_____

ANNANDALE FAMILY & SPORTS CHIROPRACTIC, PA
300 Park Street East
Annandale, MN 55302

320.274.3060

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Annandale Family & Sports Chiropractic, PA or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

Consent to Treat a Minor

Minor's Name:_____
(Please print name)

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize Annandale Family & Sports Chiropractic, PA to administer treatment as it so deems as necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at Annandale Family & Sports Chiropractic, PA which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian: _____
(Please print name)

Relationship to the minor (please circle): Custodial Parent / Legal Guardian

Social Security # of the Parent/Guardian: _____

Date of Birth of the Parent/Guardian: _____

Address of the Parent/Guardian: _____

_____

Home Phone #: _____

Work/Cell #: _____

Signature: _____
Date: ____/_____/_____

Witness (if any)
Witness' name: _____

Witness' signature _____
Date: _____/_____/_____

Annandale Family & Sports Chiropractic
300 Park Street East • Annandale, MN 55302 • PH: 320-274-3060 • Fax: 320-274-5605