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)

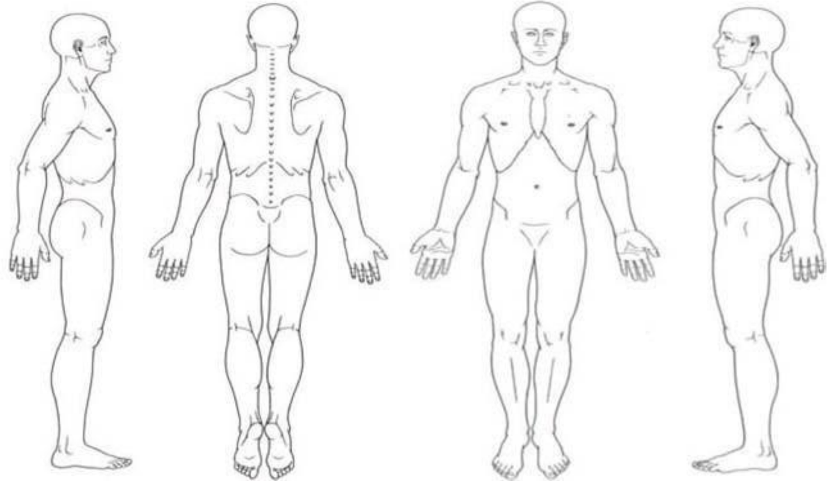
3. *What describes the nature of your symptoms?*

(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

Indicate where you have pain or other symptoms



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*** ______________

PATIENT INTAKE FORM (Page 2)

11. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

12. What aggravates your problem?
____

13. What concerns you the most about your problem; what does it prevent you from doing?
____

14. What alleviates your problem?
____

***15. What is your:* Height**___________ **Weight** _____________ **Age** ___________ **Birth Date** _________________

16. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

17. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

18 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**	**Past**	**Present**	**Past**	**Present**
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Visual Disturbances
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Dizziness
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Asthma
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Chronic Sinusitis
□	□ Arthritis	□	□ Hepatitis	**For Females Only**	
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Birth Control Pills
□	□ Cancer	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Tumor	□	□ Muscular Incoordination	□	□ Pregnancy
□	□ Other:___________________				

19. List all prescription medications you are currently taking:
____

20. List all of the over-the-counter medications you are currently taking:
____

21. List all surgical procedures you have had:
____

22. What activities do you do at work?
□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

23. What activities do you do outside of work?
____

24. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

25. Have you had significant past trauma? □ No □ Yes

26. Anything else pertinent to your visit today?______________________________________

Patient Signature____ ***Date:***____________________

PATIENT FINANCIAL INFORMATION: please print TODAY'S DATE_______________

NAME:____ SOCIAL SECURITY NUMBER:___________________

ADDRESS:____ CITY:___________________ ZIP:____________

CELL PHONE: (____) _________________ HOME PHONE:_________________DATE OF BIRTH:_______________

MARITAL STATUS: ( ) S ( ) M ( ) W ( ) D SEX: F M **E-MAIL:**___________________________

DRIVER'S LICENSE NUMBER:_________________________ STATE:_______ RESTRICTIONS:_____________

OCCUPATION:___________________________________ WORK PHONE: (____) ___________________EXT:_____

EMPLOYER: ____

WORK ADDRESS: _______________________________________ CITY:____________________ ZIP:____________

SPOUSE'S NAME:_____________________________________ EMPLOYER:___________________________________

NAME OF CLOSEST RELATIVE (other than spouse):____

RELATIONSHIP:____ HOME PHONE: (_____) __________________

REFERRED TO OUR OFFICE BY:______________________________________RELATIONSHIP:___________________

FINANCIAL INFORMATION: (how you choose to pay for services rendered)

CHOOSE ONE

( ) HEALTH INSURANCE: NAME OF INSURANCE COMPANY:____

NAME OF INSURED:________________________________INSURED'S ID NUMBER:________________

( ) AUTO INSURANCE (fill out auto accident form)

( ) WORKMAN'S COMPENSATION INSURANCE (fill out work comp form)

( ) CASH ____AT TIME OF SERVICE ____NEED TO DISCUSS PAYMENT ARRANGEMENT

PATIENT/RESPONSIBLE PARTY SIGNATURE:______________________________ DATE:___________________

AUTHORIZATION TO TREAT MINOR:

I hereby give permission to Dr(s): ____
To render chiropractic treatment to my ( ) son ( ) daughter ( ) ____

( ) PARENT ( ) GUARDIAN'S SIGNATURE:____________________________________ DATE:_______________

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME:____ RELATIONSHIP:_____________________

ADDRESS:____PHONE: (____) __________________

PLEASE READ AND SIGN BACK

FINANCIAL AGREEMENT

TO: THORPE CHIROPRACTIC OFFICE

1. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

2. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me.

3. I understand that whatever amount you do not collect from insurance proceeds (weather it be all or part of what is due), I personally owe you.

4. Should my insurance company deny benefits, for any reason, I accept responsibility for payment of any services rendered.

5. I waiver any applicable Statute of Limitations which may at any time interfere with your right to collect for services rendered to me.

6. I do not knowingly submit insurance information that is incorrect and/or invalid.

7. Should my insurance company send me a check/draft (for services rendered to me), I understand that it is my responsibility to immediately give it to you. I will not cash or deposit said check/draft to a bank account.

8. I give assignment and lien against any claims against a third party whose negligence may have caused the patient's injury, up to the amount of the bill for treatment and including interest, attorney and court fees.

9. In the event that any section or provision of this Agreement is legally void, invalid, or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.

DATE:__________________________ ______________________________________

PATIENT'S SIGNATURE

____

PARENT OR GUARDIAN'S SIGNATURE

____

SIGNATURE OF WITNESS

A photocopy of this financial agreement shall be considered as effective and valid as the original.