

# BLOCK CHIROPRACTIC

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Prov: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Social Security # \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Business Employer: \_\_\_\_\_ Circle One: Married Single Widowed Divorced Separated

Business Phone: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Birthday \_\_\_\_\_

Number of Children: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Referred To This Office By: \_\_\_\_\_

Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who is Responsible For Your Bill, You and  Spouse  Workers' Comp.  Auto Insurance  Medicare  Medicaid  Personal

Health Insurance (Name) \_\_\_\_\_  Health Card (#) \_\_\_\_\_

***I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that ABS Chiropractic, P.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to ABS Chiropractic, P.C. will be credited to my account on receipt. However, I clearly understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable. I also understand that I am directly and fully responsible to said doctor for any professional bills submitted for services rendered me and that this agreement holds me fully responsible for any moneys owed. In the event of non-payment, I am legally responsible for any collection fees including but not limited to, reasonable attorney fees incurred by ABS Chiropractic in satisfying my debt.***

***I hereby authorize ABS Chiropractic, P.C. to treat my condition as he or she deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid to the Doctor, is for examination, x-rays and treatment only. The X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.***

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's  
Signature or Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

# BLOCK CHIROPRACTIC

Below are lists of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        | <b>INTAKE</b>                        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Coffee      |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Tea         |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Alcohol     |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           |                                      |
- Have you been tested HIV positive?  Yes  No

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL CODE**

- |   |   |
|---|---|
| <input type="checkbox"/> Low Bac, Pain          | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Heartburn                |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Black/Bloody Stool       |
| <input type="checkbox"/> Arm Pain               | <input type="checkbox"/> Colitis                  |
| <input type="checkbox"/> Joint Pain/Stiffness   |   |
| <input type="checkbox"/> Walking Problems       |   |
| <input type="checkbox"/> Difficult Chewing      |   |
| <input type="checkbox"/> General Stiffness      |   |

**GENITO-URINARY CODE**

- Bladder Trouble  
 Painful/Excessive Urination  
 Discolored Urine

**FEMALES ONLY:**

When was your last period? \_\_\_\_\_

Are you pregnant?

- Yes  No  Not Sure

**Vitamin History:**

Please list the current vitamins you take

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**NERVOUSE SYSTEM CODE C-V-R CODE**

- |  |   |
|--|---|
| <input type="checkbox"/> Nervous                   | <input type="checkbox"/> Chest pain               |
| <input type="checkbox"/> Numbness                  | <input type="checkbox"/> Short Breath             |
| <input type="checkbox"/> Paralysis                 | <input type="checkbox"/> Blood Pressure Problems  |
| <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Irregular Heartbeat      |
| <input type="checkbox"/> Forgetfulness             | <input type="checkbox"/> Heart Problems           |
| <input type="checkbox"/> Confusion/Depression      | <input type="checkbox"/> Lung Problems/Congestion |
| <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Varicose Veins           |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Ankle Swelling           |
| <input type="checkbox"/> Cold/Tingling Extremities | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Stress                    |   |

**GENERAL CODE**

- Fatigue  
 Allergies  
 Loss of Sleep  
 Fever  
 Headaches

**EENT CODE**

- Vision Problems  
 Dental Problems  
 Sore Throat  
 Ear Aches  
 Hearing Difficulty  
 Stuffed Nose

**GASTRO-INTESTINAL CODE MALE/FEMALE CODE**

- |  |  |
|--|--|
| <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Menstrual Irregularity      |
| <input type="checkbox"/> Excessive Thirst        | <input type="checkbox"/> Menstrual Cramps            |
| <input type="checkbox"/> Frequent Nausea         | <input type="checkbox"/> Vaginal Pain/Infection      |
| <input type="checkbox"/> Vomiting                | <input type="checkbox"/> Breast Pain/Lumps           |
| <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Prostate/Sexual Dysfunction |
| <input type="checkbox"/> Constipation            | <input type="checkbox"/> Other Problems              |
| <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> _____                       |
| <input type="checkbox"/> Liver Problems          | <input type="checkbox"/> _____                       |
| <input type="checkbox"/> Gall bladder Problems   | <input type="checkbox"/> _____                       |
| <input type="checkbox"/> Weight Trouble          |  |
| <input type="checkbox"/> Abdominal Cramps        |  |

**FAMILY HISTORY**

The following members have a same or similar problems as I do.

- Mother  
 Father  
 Brother  
 Sister  
 Spouse  
 Child

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved. (Corrective Care). Your Doctor will weigh your needs and desires when recommended your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care     Corrective Care     Check here if you want the Doctor to select the type of care appropriate for your condition.

Patient's Signature \_\_\_\_\_

# 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**

\_\_\_\_\_

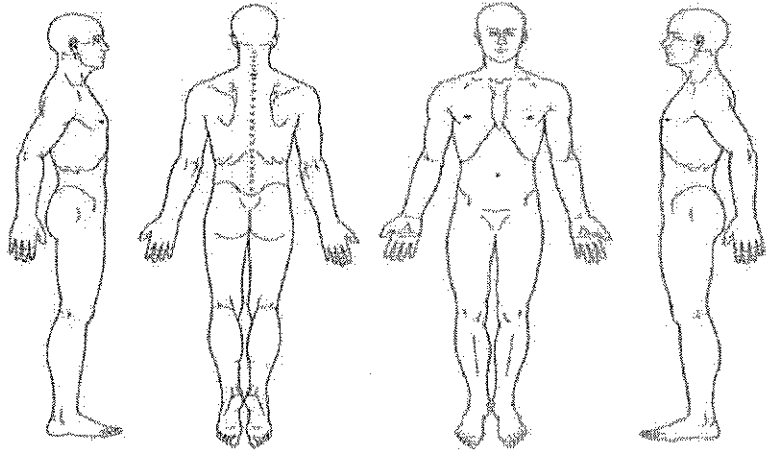
\_\_\_\_\_

a. When did your symptoms start? \_\_\_\_\_

b. How did your symptoms begin? \_\_\_\_\_

**2. How often do you experience your symptoms? 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. During the past 4 weeks:**

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable ⑩

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

**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 \_\_\_\_\_

**Consent For Use And/Or Disclosure Of Protected Health Information To Carry Out Treatment, Payment And/Or Healthcare Operations**

Through the use of this consent form \_\_\_\_\_ (referred to as the or this "office")  
is notifying you and agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.
2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.
4. The following appointment reminders will be used by this office: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.
5. This office reserves the right to change its privacy practices that are described in the above-referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
6. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations.
7. This office is not required to agree to any restrictions on your health information that you have requested.
8. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.
9. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all future transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of a previously signed consent.
10. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.
11. You must sign and date all consents and authorizations requested to which you agree.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

\_\_\_\_\_  
Name of Patient/Individual (Please Print)

\_\_\_\_\_  
Signature of Patient/Individual

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness