HEUSER CHIROPRACTIC
144 W. 32nd St. • Yuma, AZ 85364
928.726.8847 • Fax 928.341.0417

PATIENT INFORMATION FORM

Full Name _____ Date _____

Address _____ Apt _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Email Address _____ Cell Phone _____

Date of Birth _____ Sex ____ Marital Status ___ Spouse's Name _____

Occupation _____ Children (Ages) _____

Employer _____ Employer Address _____

Social Security # _____ Drivers License # _____ State _____

How did you hear about our office? _____

Name of personal physician _____

Nearest relative not living with you, (emergency contact) _____

Relationship _____ Phone _____ Address _____

Who is responsible for this account? _____

Type of payment you plan to use, (circle), Insurance / Cash / Credit Card / Other _____

ACCIDENT-INJURY INFORMATION

Are your present problems due to an accident or injury _____ Date of accident or injury _____

Type of accident/injury, (circle): Auto/On-the-job/Sports/Military/Household/Slip & Fall/Personal/Other _____

Name of Attorney handling your case _____ Phone # _____

INSURANCE INFORMATION

Type of insurance you plan to use to help pay your account, (circle): Auto/Work Comp/Group/Medicare/Other _____

Name of Insurance Company _____ Phone # _____

Insured's Name/Date of Birth _____ ID # _____ Group # _____

If insurance is your spouses please list spouses employer: _____

TREATMENT AUTHORIZATION

I hereby authorize this office and its staff and doctors to examine and treat me or my above mentioned dependents condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me or my dependent are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my or my dependents behalf. Should collection of a past due amount become necessary. I will become responsible for all charges, fees and attorney fees. All charges for services and care given will be charged directly to me and I will be responsible for payment of them. I give my permission to be called by telephone concerning my or my dependents appointments or treatment, even if my name and number are on a state or national no call list. Please also be aware we do use audio and video recording throughout this office.

We realize today's free spinal examination includes, but is not limited to a consultation, history of the complaint and examination/palpation of the area involved to determine if there is a need for chiropractic care. However, the free screening does not include x-rays or treatment and is limited to one free exam per individual. If x-rays are indicated it is customary to pay for x-rays when taken unless deposit arrangements are made in advance. We are required by Law to advise you of the fees for our services. They are as follows: X-ray views 8x10 $35 each; 14x17 view $45 each; copies of x-rays $10; Spinal Manipulations $50. All therapies are $40 except for Decompression which is $65, Rehab $80, Laser $50 and Ultrasound $50. Please rest assured our staff/manager will review all charges before treatment is administered.

I have received a copy of the "Notice of Privacy Practices" for me to keep for my records.

Patient/Guardian Signature (x) _____ Date _____

PREVIOUS HEALTH PROBLEMS

Circle all the Apply:

General:
Weight Loss Fatigue
Weakness Trouble Sleeping

Skin:
Rashes
Bumps
Color Changes

Eyes:
Vision Loss/Change Eye Pain
Blurred Vision

Throat:
Dry Mouth
Sore Throat
Hoarseness

Respiratory:
Chronic Cough
Bronchitis
Pneumonia
Asthma
Wheezing
Difficulty Breathing

Cardiovascular
Chest Pain or Discomfort
Palpitations
History of Aneurysm
Cold hands or feet
Heart Attack
Stroke

Gastrointestinal:
Heart Burn
Nausea
Change in bowel habits
Constipation
Diarrhea

Urinary:
Frequency
Urgency
Incontinence
Bed-wetting

Neurological:
Dizziness
Weakness
Numbness
Tremor
Memory Loss
Depression
Stress
Ringing in Ears

Implants:
Pacemaker
Other Electronic Implants
Joint Replacements
Metal Screws/Implants

Other Symptoms:
Headaches
Neck Pain
Tight Muscles
Muscle Spasms
Pain Down Arms
Numbness Hands/Feet
Pain Between Shoulders
Abdominal Pain
Hip Pain
Pain Down Legs
Knee Pain
Foot Pain or Numbness
Mid Back Pain
Muscle or Joint Pain
Allergies

Broken Bones and/or Fractures:_____
Head Trama/When:_____
Surgeries:_____
Other Serious Illness:_____
_____

Are you pregnant? Yes / No
Smoking Status (Circle One) Every Day Smoker/Occasional Smoker/Former Smoker/Never Smoked

Are you currently taking any Medications? (Please include regularly used over the counter medications)

Medication Name:	Dosage and Frequency (i.e. 5mg once a day ect.)
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any medication allergies?

Medication Name:	Reaction:	Onset Date:	Additional Comments
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE- PHQ

Patient Name _____ Date: _____

1. Describe your symptoms: _____

_____

_____

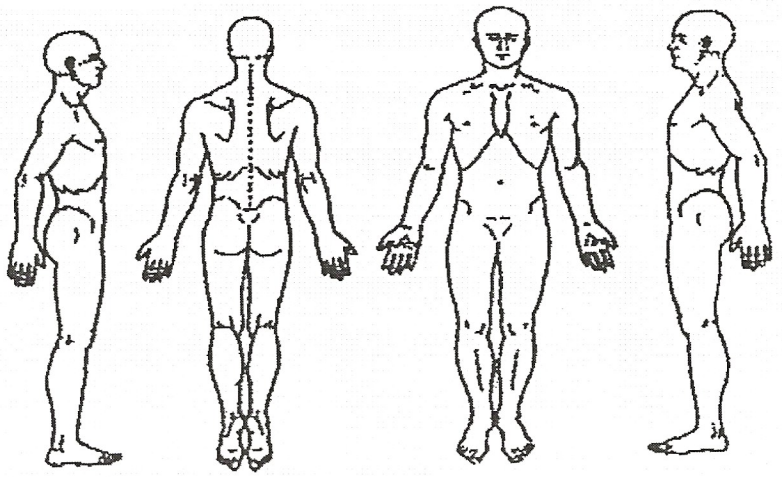
a. When did your symptoms start? _____

_____

b. How did your symptoms start? _____

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 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>: None Unbearable

a. Indicate the average intensity of your symptoms 0 1 2 3 4 5 6 7 8 9 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 your friends)

1. All the time 2. Most of the time 3. Some of the time 4. A little bit 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 3. Medical Doctor 5. Other
2. Other chiropractor 4. Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

1. X-rays - 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 3. Medical Doctor 5. Other
2. Other chiropractor 4. Physical Therapist

10. What is your occupation?

1. Professional/Executive 4. Laborer 7. Retired
2. White collar/Secretarial 5. Homemaker 8. Other
3. Trades person 6. FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

1. Full-time 3. Self-employed 5. Off work
2. Part-time 4. Unemployed 6. Other

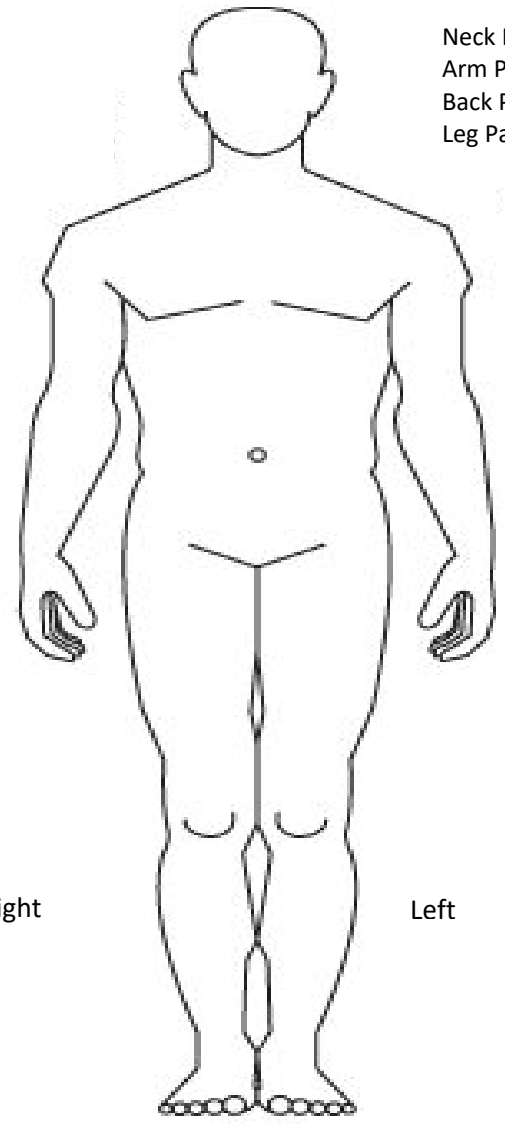
Patient Signature _____ Date _____

Patient Name:_____ Age: _____ Date:_____

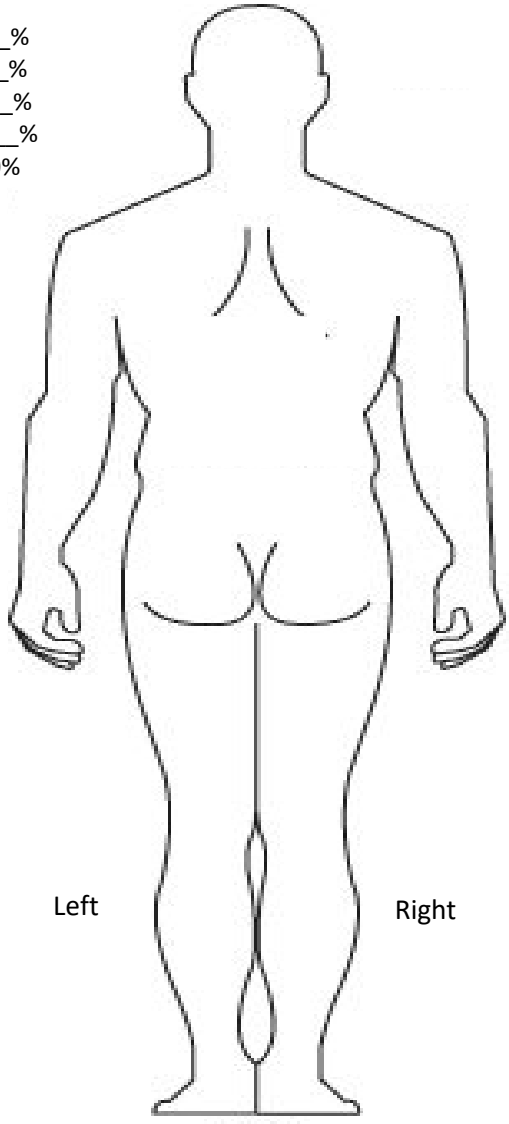
Where is your Pain now? Mark the area on the body where you feel the described sensations. Use the appropriate symbol , mark the areas of radiation. Include all affected areas, Just to complete the picture, please draw your face.

Ache: ^^^ ^^^	Numbness: ooo ooo	Pins & Needles: [][][] [][][]	Burning: xxx xxx	Radiating Pain: /// ///

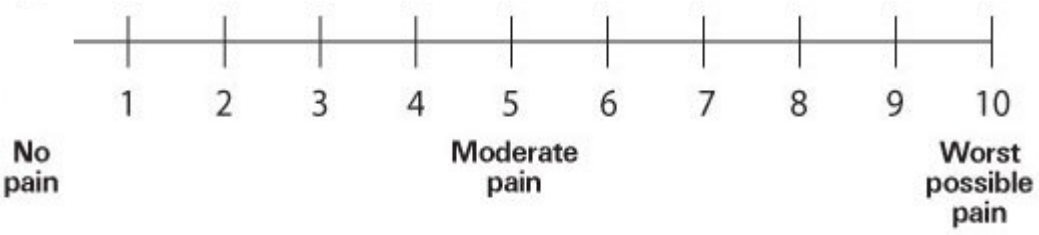
Neck Pain _____%
Arm Pain _____%
Back Pain _____%
Leg Pain _____%
Total = 100%



Right Left



Left Right

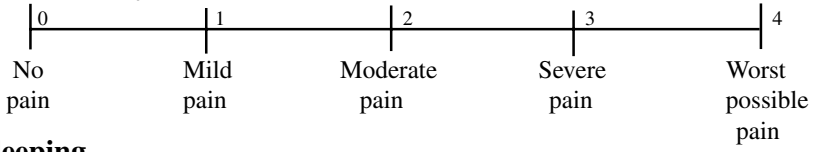


Functional Rating Index

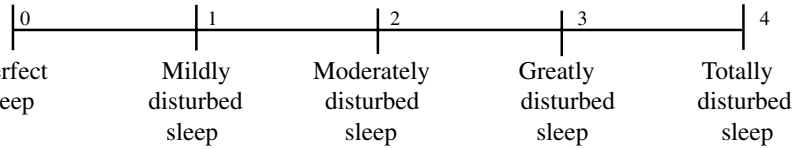
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

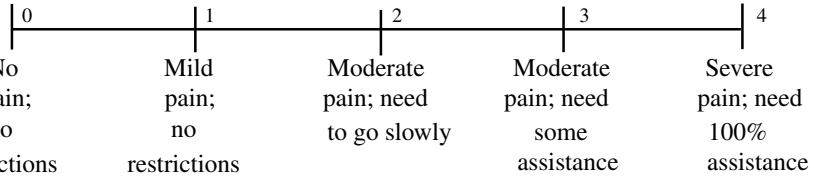
1. Pain Intensity



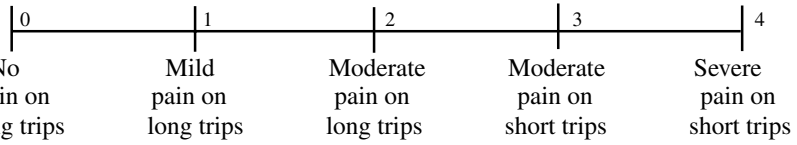
2. Sleeping



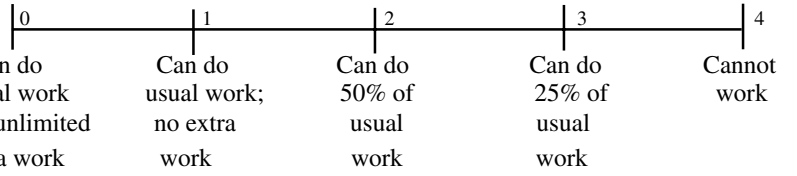
3. Personal Care (washing, dressing, etc.)



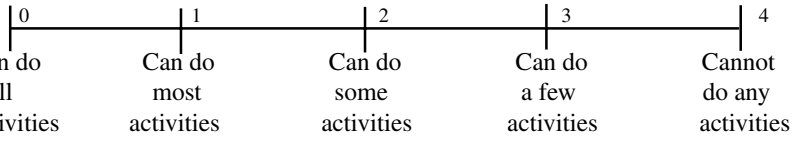
4. Travel (driving, etc.)



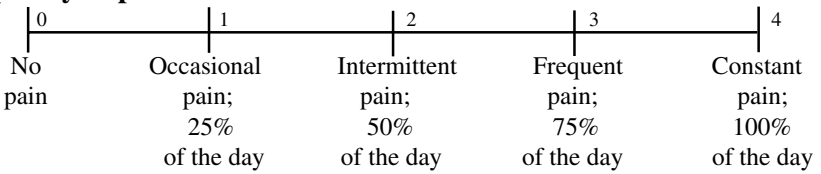
5. Work



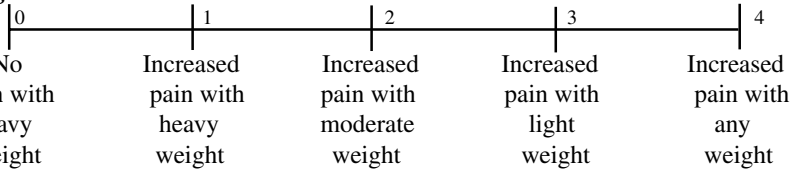
6. Recreation



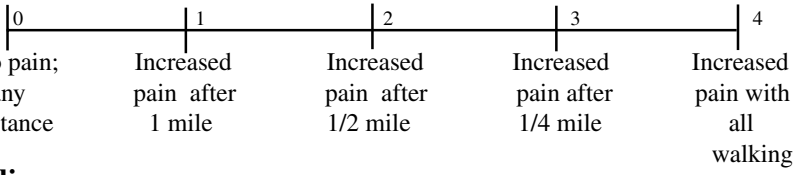
7. Frequency of pain



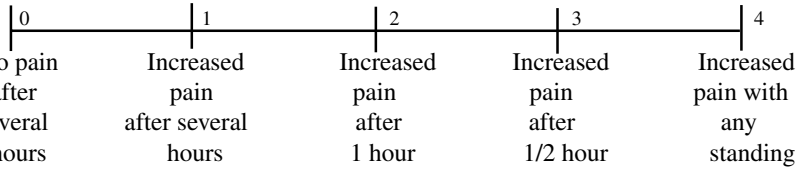
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

New Patient ( ) or Update ( )

Heuser Chiropractic

Please Print:
Were You Referred by: Physician ( ) Friend ( ) Other: ( ) _____

PATIENT INFORMATION

Name:_____ Social Security #:_____-_____-_____
(last) (First) (MI)
Mailing Address (If PO Box required) Age_____ Birth Date:_____ Sex: M___F___
_____
Street City State Zip Code

PATIENT EMPLOYER

Date of Injury: ____/____/____ Work Related: Y___ No___

Name:_____ Dept: _____
Address:_____
Street City State Zip Code
Phone Number: (_____) _____ - _____

GUARANTOR INFORMAITON

Name:_____
(last) (First) (MI)
Address:_____
_____
Phone Number: (_____)_____-_____
SSN:_____-____-_____ Insured Date of Birth___/___/___

GUARANTOR EMPLOYER

Name:_____
Address:_____
_____
Phone Number: (_____)_____-_____
Relationship to Patient:_____

NEXT OF KIN

Name:_____
(last) (First) (MI)
Phone Number: (_____)_____-_____
Relationship to Patient:_____

ALTERNATE PERSON TO NOTIFY

Name:_____
(last) (First) (MI)
Phone Number: (_____)_____-_____
Relationship to Patient:_____

INSURANCE INFORMATION	POLICY NUMBER	GROUP NUMBER	SUBSCIBER
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

WE WILL NEED A COPY OF YOUR CURRENT INSURANCE CARD TO BILL YOUR INSURANCE CARRIER

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I hereby give authorization for payment of Insurance Benefits to be made directly to Heuser Chiropractic and any assisting physicians and/or billing for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by the insurance. In the event of default, I agree to pay all cost of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I agree that a photocopy of this agreement shall be valid as the original.

I AM AWARE THAT THESE CHARES ARE ESTIMATES ONLY AND THAT I MAY RECEIVE ADDITIONAL BILLING.

Patient, Parent, Guardian
Signature:_____ **Date**:_____/_____/_____
MO Day Year