

# PATIENT DATA SHEET

## GENERAL INFORMATION

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

\_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE INITIAL

\_\_\_\_\_  
ADDRESS CITY STATE ZIP CODE

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME PHONE WORK PHONE CELL PHONE

\_\_\_\_\_  
EMAIL ADDRESS

SEX (PLEASE CIRCLE) MALE FEMALE

MARITAL STATUS (PLEASE CIRCLE) SINGLE LEGALLY SEPARATED MARRIED WIDOWED DIVORCED

\_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_-\_\_\_\_-\_\_\_\_  
BIRTHDATE SOCIAL SECURITY

\_\_\_\_\_  
REFERRED BY (EXAMPLE: DR, FRIEND, ETC - PLEASE NAME)

## EMPLOYER INFORMATION

WORK STATUS (PLEASE CIRCLE) EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT SELF-EMPLOYED  
HOMEMAKER OTHER

\_\_\_\_\_  
OCCUPATION/ TYPE OF WORK

\_\_\_\_\_  
EMPLOYER

\_\_\_\_\_  
EMPLOYER ADDRESS CITY STATE ZIP CODE

\_\_\_\_\_  
EMPLOYER CONTACT PERSON ( ) PHONE

## CONDITION INFORMATION

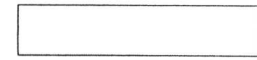
IS YOUR CURRENT COMPLAINT THE DIRECT RESULT OF: (PLEASE CIRCLE) WORK ACCIDENT YES NO AUTO ACCIDENT YES NO ACCIDENT DATE

OTHER? (EXPLAIN) \_\_\_\_\_

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

# 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?

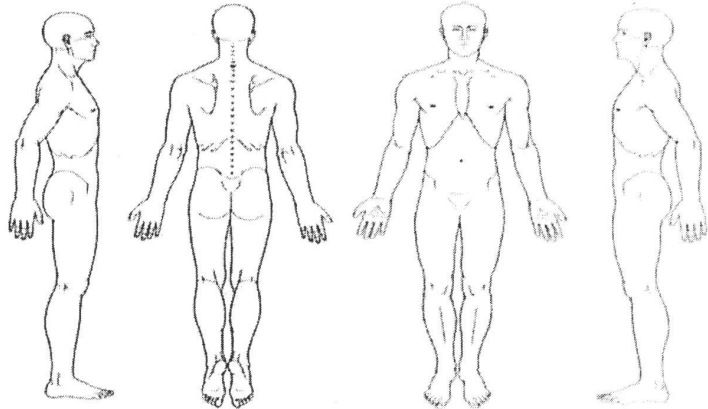
\_\_\_\_\_

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: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan 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 Financial Policy**

**Medicare patients - including those with Medicare HMO's such as Security Blue, Freedom Blue, UPMC for Life, and Advantra:**

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Your insurance plan will only cover chiropractic manipulation of the spine. It does NOT cover the initial examination for any type of new injury. The initial examination is where a history of the present illness is taken as well as an examination to determine what type of care should be delivered. This process requires time and paper work from my staff as well as a significant amount of my time during the history and examination. Examination costs vary with complexity, however, most of the time the cost will be between \$40 and \$150. Also, certain adjunctive procedures may be required in addition to spinal manipulation to help speed up the healing process. Examples of adjunctive procedures include electrical muscle stimulation for spasms, traction for pinched nerves, and flexibility/stability rehabilitative exercises. These may not be covered by your insurance plan as well. Please remember that this will be an additional charge above any co-pays or coinsurance.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office's services are due at the time of service. We will accept VISA, MasterCard, Discover, American Express, cash or check, and CareCredit.
- Your insurance policy is a contract between you and your insurance company. **It is not our responsibility to keep track of your benefits or whether you are about to exhaust your benefits. Patients are expected to monitor this as they would their bank account.** As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. We cannot be held accountable for any false or misinformation given to our office by you or your insurance carrier.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fee, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of \$25.00 for all returned checks plus our banks NSF Charge at the time. Your insurance company does not cover this fee.

**Signature of Patient/Responsible Party:** \_\_\_\_\_

Printed Name of Patient/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_ Patient initials to indicate copy received.