Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________________ ***Date*** ____________________

1. When did your symptoms start: ____________________ ***Describe your symptoms and how they began:***

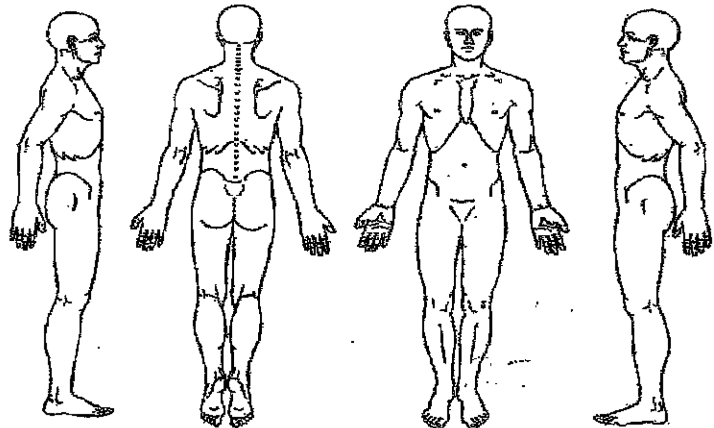
____

____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	0	1	2	3	4	5	6	7	8	9	10
b. best:	0	1	2	3	4	5	6	7	8	9	10

6. How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: ______________________

8. What activities make your symptoms better: ______________________

9. Who have you seen for your symptoms? ☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. When and what treatment? ______________________

b. What tests have you had for your symptoms and when were they performed?
☐ Xrays *date:* __________ ☐ CT Scan *date:* __________
☐ MRI *date:* __________ ☐ Other *date:* __________

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? ☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

11. What is your occupation? ☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker ☐ FT Student ☐ Retired ☐ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status? ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other

12. What do you hope to get from your visit/treatment *(select all that apply)*:

- ☐ Reduce symptoms
- ☐ Resume/increase activity
- ☐ Explanation of condition/treatment
- ☐ Learn how to take care of this on my own
- ☐ How to prevent this from occurring again
- ☐

Patient Signature ______________________________ ***Date*** ______________

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** ____________

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height [ ] [ ] (Feet, Inches) Weight [ ] [ ] [ ] lbs.

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	Condition
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain.
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	Condition
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	Condition
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

Past	Present	Condition
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	

Other Health Problems/Issues

Past	Present	Condition
☐	☐	Pacemaker
☐	☐	
☐	☐	

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

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ ____________

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

____

____

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

____

____

Patient Signature ______________________ **Date** ____________

Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ **Date** ____________

HEALTH & PERFORMANCE CENTER

1962 Craigshire Rd. *Saint Louis, MO 63146* *Telephone: (314) 628-9838*

Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI)

To carry out Treatment, Payment and Healthcare Operations

______________________, hereby states that by signing this Consent I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing the Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided in the lobby and on the Practice's website at www.hpc-stl.com. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information

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 Individual (Printed) Signature of Individual

______________________ ____________ ______________________

Signature of Legal Representative Date Signed Relationship

____

Witness

HEALTH &
PERFORMANCE
CENTER

1862 Craigshire Rd. *Saint Louis, MO 63146* *Telephone: (314) 628-9898*

Consent to Chiropractic Services

1. I, ______________________, authorize the performance upon myself of the following procedure(s): Chiropractic Adjustments, Tractioning (to restore normal curves), Posture Specific Exercises, and/or any other therapeutic procedures other than those stated above that HPC Physicians and/or assistants may consider necessary or advisable in the course of my health care.

2. The nature and purpose of the procedures, possible alternatives, risks involved, the possible consequences, and the possibility of complications have been explained to my satisfaction by HPC Physicians and/or assistants.

3. I acknowledge that no guarantee or assurance of the results that may be obtained from the procedures has been given by HPC Physicians and/or assistants.

Date: ____________ Signed: ______________________

Witness: ______________________

1862 Craigshire Rd.| St Louis MO 63146

Health & Performance Center
Release of Records

I, ____

Print Name   Sign Name   Date

Hereby authorize the release of my medical records and/or x-rays
(or copies of)

To/From:

Dr, ________________

Health & Performance Center
1862 Craigshire Rd.
St. Louis MO 63146

Phone: (314) 628.9898
Fax: (314) 628.9728

To/From:
Dr.______________________

Address:______________________________

City: ____________________ State:_____________ Zip:________

Phone: ____________________
Fax: ______________________

Perfect Plan Survey

Name:____________________________

Your answers will help the doctor provide a plan that is specifically tailored to your desire.

Question #1 – How well do HPC hours fit with your schedule? (circle one)

Monday & Wednesday – 7:30-11:00am and 3:00-6:00pm (early & late)

Tuesday – 11:00am-2:00pm **Thursday** – 9:30am-2:00pm (lunch)

Friday – 7:30am-12:00pm (combo)

They fit great **They're good** **They're tough** **They're very difficult**

Question #2 – How severe/annoying is your problem? (circle one)

Not too bad **Starting to affect me** **Definitely getting better** **It is TERRIBLE**

Question #3 – How badly do you want your problem to go away? (circle one)

It would be nice **It would help a lot** **It needs to be gone** **I am desperate**

Question #4 – What type of care are you interested in? (circle one)

Relief – Pain is relieved

Relief & Correction – Pain goes away and the cause of the pain is addressed

Relief, Correction & Maintenance – Pain can stay away; causative factors are constantly addressed

Relief **Relief & Correction** **Relief, Correction & Maintenance**

Question #5 – How long do you believe it will take to achieve your answer to question #4? (circle one)

Days **Weeks** **Months** **Years**

Question #6 – In order to manage your care as effectively as possible, we would like to have the name of your primary car physician. If you have an internist or family practice medical/osteopathic/naturopathic doctor, please provide as much of the following information as you can.

PCP Name:________________________________General Location:__________________________

Office/Group Name:__________________________Phone/email/website:_____________________

Patient Information

Name:

First____________________**M.I.**____________**Last**_____________________

Birthday:

Month_______________**Day**___________**Year**___________

Contact Information:

Home #___________________________

Cell #____________________________

Email___________________________________

Referred By:

____

Address:

City______________________________**State**_________________**Zip**_____________

Employer:

Status_____________________**Occupation**_______________________________

Employer____

Employer Address:

City______________________________**State**__________________**Zip**_____________