



# Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

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

Patient Name \_\_\_\_\_

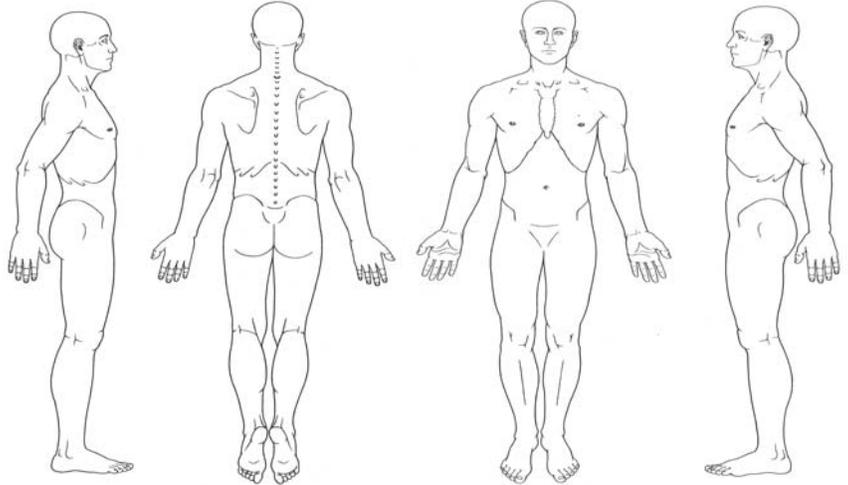
Date \_\_\_\_\_

1. When did your symptoms start: \_\_\_\_\_

Describe your symptoms and how they began: \_\_\_\_\_

**2. How often do you experience your symptoms? 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. How bad are your symptoms at their:**

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

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

- |               |                               |                                    |                                  |                                          |                              |   |   |   |   |
|---------------|-------------------------------|------------------------------------|----------------------------------|------------------------------------------|------------------------------|---|---|---|---|
| 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?**

- ① No One
- ③ Medical Doctor
- ⑤ Other
- ② Other Chiropractor
- ④ Physical Therapist

a. When and what treatment? \_\_\_\_\_

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: \_\_\_\_\_

**10. 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

**11. What is your occupation?**

- ① Professional/Executive
- ④ Laborer
- ⑦ Retired
- ② White Collar/Secretarial
- ⑤ Homemaker
- ⑧ Other
- ③ Tradesperson
- 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

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

- ① Reduce symptoms
- ③ Explanation of condition/treatment
- ⑤ How to prevent this from occurring again
- ② Resume/increase activity
- ④ Learn how to take care of this on my own
- ⑥

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_





## Consent for Purposes of Treatment, Payment and Healthcare Operations

I, \_\_\_\_\_ [Name of Individual] consent to Colleyville Chiropractic's use and disclosure of my Protected Health Information **for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.** Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if Colleyville Chiropractic agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority



# COLLEYVILLE CHIROPRACTIC

Patient: \_\_\_\_\_

File #: \_\_\_\_\_

## Consent to Chiropractic Services

### Explanation of Risks

Manipulation is considered one of the safest methods available for the treatment of many spinal and joint disorders. Every reasonable precaution is taken to reduce the risk of adverse effects for this and any treatment. However, as with any health care procedure, there are certain complications which may arise during a manipulative adjustment. Those complications include but are not limited to: (1) Temporary aggravation of symptoms; (2) Other unlikely, but possible complications being stretch injuries to muscles, tendons and soft tissue, fracture or displacement of bones, disc injuries, injuries to nerves and occlusion of the blood vessels. Some types of manipulation of the neck have been associated with rare injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Please note the exact incidence of serious complication is described as rare or very rare.

I hereby consent to the performance of chiropractic procedures and diagnostics that the doctor of chiropractic may consider necessary or advisable in the course of my health care. I have read and understand the explanation of risks and I acknowledge that no guarantees have been made to me concerning the result of treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Consent to Treatment of a minor child

I authorize the licensed chiropractor and whomever she may designate as assistants to administer treatment to my \_\_\_\_\_ (relationship), \_\_\_\_\_.

\_\_\_\_\_  
Signature of legal guardian

\_\_\_\_\_  
Date