

Chiropractic Injury and Recovery Center Patient Enrollment Form

Today's Date: ___ / ___ / ___

PATIENT INFORMATION

Name: _____ Date problem began: ___ / ___ / ___
Address: _____ City: _____ State _____ Zip _____
Home phone: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____
E-mail: _____ Soc. Sec.# _____ - _____ - _____
Birthdate: ___ / ___ / ___ Age: ___ Ht. ___ Wt. ___ Sex: M / F Marital Status: S M D W

EMPLOYMENT INFORMATION

Employment Status: Employed ___ Part-time Student ___ Full-time Student ___ Other _____
Employer: _____ Occupation: _____

SPOUSE INFORMATION

Name: _____ Birthdate: ___ / ___ / ___ Phone: (____) _____ - _____

Whom may we thank for referring you? _____ Relationship _____

Health History

Do you have any hereditary conditions in you immediate family? (Please circle all that apply and indicate mother, father, brother, sister, grandfather and or grandmother.)

Heart Disease _____ Cancer _____ Arthritis _____ Diabetes _____

Asthma _____ High Blood Pressure _____ Other _____ / _____

Do you currently suffer from any other medical problems? _____ Explain _____

List any hospitalizations you have had. _____

List any major injuries/accidents. _____

List all prior surgeries will all dates. _____

Are you taking any medications? _____ Please list. _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

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

Patient Name _____ Date _____

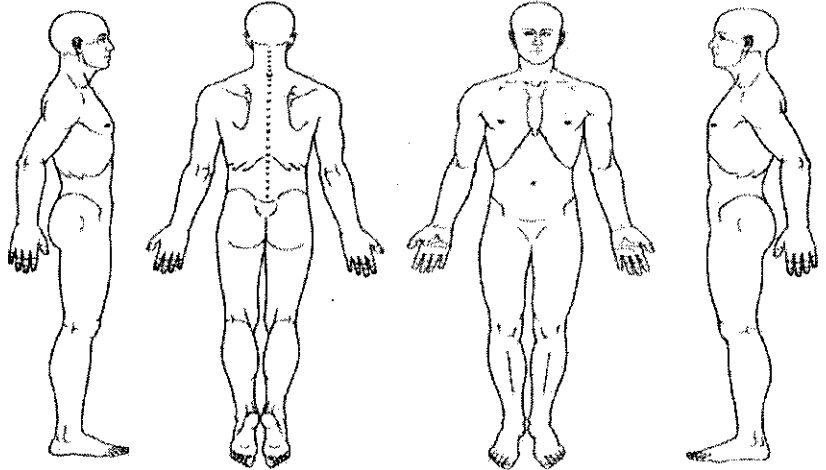
1. Describe your symptoms

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 Other 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 Other 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 _____

PREGNANCY WARNING AND CONSTENT FOR X-RAY

I, _____ herby certify that to the best of my knowledge I am not pregnant and that the doctors of this clinic have my permission to perform a diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual period: _____
I FURTHER AGREE TO NOIFTY THIS OFFICE IN WRITING DURING THE COURSE OF MY TREATMENT SHOULD I BECOME PREGNANT.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR TREATMENT AND CONSENT FOR CARE

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an insurance carrier and myself, however, Chiropractic Injury and Recovery Center may accept certain insurance assignments of benefits. I understand and agree that I am ultimately responsible for any payment that my insurance carrier or any third party payer does not pay. The acceptance of insurance is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable. Furthermore, I hereby voluntarily consent to examination, diagnostic treatment and/or Chiropractic care by Chiropractic Injury and Recovery Center, its physicians and employees as explained to me by the attending physician and whomever he may designate as his assistant. I am aware that the science of Chiropractic/Medicine is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees have been made to me as a result of any treatment or examination in the office.

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE and relationship: _____

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____
(Name of Insured / Patient) (Name of Insurance Carrier)
to make medical benefits payments otherwise payable to me for services rendered by CHIROPRACTIC INJURY AND RECOVERY CENTER, but not to exceed the charges of those services, payable to and mailed directly to:

**Chiropractic Injury and Recovery Center
4705 26th Street West, Suite B
Bradenton, FL 34207**

Furthermore, I hereby IRREVOCABLY ASSIGN to CHIROPRACTIC INJURY and RECOVERY CENTER the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by CHIROPRACTIC INJURY and RECOVERY CENTER.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 20__.

PATIENT'S SIGNATURE

PATIENT'S NAME (PLEASE PRINT)

AUTHORIZATION FOR RELEASE OF RECORDS

TO: _____

DATE: _____
FROM: Chiropractic Injury and Recovery Center
4705 26th Street West, Suite B
Bradenton, FL 34207

I authorize and request you to release any and all records in your possession, including x-rays, concerning this patient:

(Patient Signature) _____ (Print Name) _____

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND
MAINTAINED FOR SIX YEARS.**