BROADWAY CHIROPRACTIC WELLNESS CENTER

P.O. BOX 533, 1510 N. Broadway New Ulm, MN 56073 (507) 359-4374

NAME____DATE___/___11

COMPLETE ADDRESS____

DOB___/___/______ MARITAL STATUS: M S W D # OF CHILDREN ____ RETIRED ___ YES ___ NO

HOME PHONE ( )____-________ WORK PHONE ( )____-________ SOCIAL SEC #___________________

OCCUPATION________________________________EMPLOYER________________________________

IS THIS CONDITION WORK RELATED YES____ NO____ DID YOU MISS WORK YES____ NO____

DATE OF LAST PHYSICAL EXAMINATION____/____/____ BY WHOM_____________________________

REFERRED TO OUR OFFICE BY____

E-MAIL:_______________________@___________________________ INERNET ACCESS ___YES ___NO

Check areas you are interested in:

- □ BETTER HEALTH
- □ DETOX/CLEANSE PROGRAM
- □ WELLNESS PROGRAM
- □ NUTRITION PROGRAM
- □ WEIGHT LOSS
- □ MASSAGE THERAPY
- □ CHIROPRACTIC MAINTENANCE PROGRAM
- □ DRUG FREE MANAGEMENT OF CHRONIC CONDITIONS
- □ INCREASED ENERGY/FITNESS
- □ SAUNA

I herewith authorize Dr. F. Falentin to administer care to my daughter_______________son___________________

"PAYMENT ARRANGEMENTS ARE MADE AT TIME OF YOUR FIRST VISIT"

PERSON RESPONSIBLE FOR PAYMENT_____________________ARE YOU INSURED? YES____ NO____

_____(Initials) I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that BROADWAY CHIROPRACTIC will prepare any reports and forms necessary to assist me in making collection from the insurance company and that any amount authorized to be paid directly to BROADWAY CHIROPRACTIC will be credited to my account upon receipt. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

_____(Initials) I authorize this health care facility to release all information related to the care I receive, to my HMO, insurance company, third party payor, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.

Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headaches and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please don't hesitate to speak with your Doctor of Chiropractic.
As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, or disk injuries. **These are extremely rare occurrences.**

____ ________________________

Signature of Patient or Responsible Party Date Relationship to Patient (if applicable)

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 ______________________

____

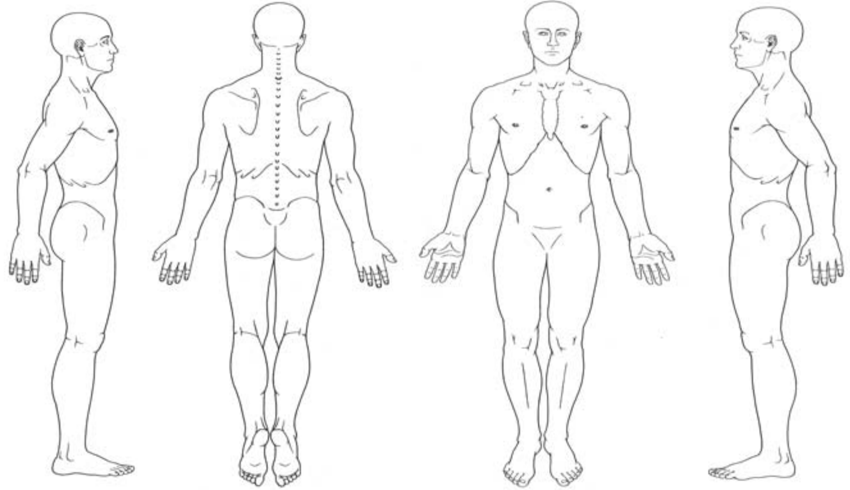
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?

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)

Indicate where you have pain or other symptoms



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 past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

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:* ________ 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 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** ______________

PATIENT INTAKE FORM (Page 2)

11. Do you consider this problem to be severe? Yes Yes, at times No

12. What aggravates your problem?

____

13. What concerns you the most about your problem; what does it prevent you from doing?

____

14. What alleviates your problem?

____

15. What is your: Height__________ Weight ____________ Age __________ Birth Date ______________

16. What type of exercise do you do? Strenuous Moderate Light None

17. Indicate if you have any immediate family members with any of the following:
Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS

18 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		Past	Present		Past	Present	
		Headaches			High Blood Pressure			Diabetes
		Neck Pain			Heart Attack			Excessive Thirst
		Upper Back Pain			Chest Pains			Frequent Urination
		Mid Back Pain			Stroke			Smoking/Tobacco Use
		Low Back Pain			Angina			Drug/Alcohol Dependance
		Shoulder Pain			Kidney Stones			Allergies
		Elbow/Upper Arm Pain			Kidney Disorders			Depression
		Wrist Pain			Bladder Infection			Systemic Lupus
		Hand Pain			Painful Urination			Epilepsy
		Hip Pain			Loss of Bladder Control			Dermatitis/Eczema/Rash
		Upper Leg Pain			Prostate Problems			HIV/AIDS
		Knee Pain			Abnormal Weight Gain/Loss			Visual Disturbances
		Ankle/Foot Pain			Loss of Appetite			Dizziness
		Jaw Pain			Abdominal Pain			Asthma
		Joint Pain/Stiffness			Ulcer			Chronic Sinusitis
		Arthritis			Hepatitis			For Females Only
		Rheumatoid Arthritis			Liver/Gall Bladder Disorder			Birth Control Pills
		Cancer			General Fatigue			Hormonal Replacement
		Tumor			Muscular Incoordination			Pregnancy

Other:____

19. List all prescription medications you are currently taking:

____

20. List all of the over-the-counter medications you are currently taking:

____

21. List all surgical procedures you have had:

____

22. What activities do you do at work?

Sit:	Most of the day	Half the day	A little of the day
Stand:	Most of the day	Half the day	A little of the day
Computer work:	Most of the day	Half the day	A little of the day
On the phone:	Most of the day	Half of the day	A little of the day

23. What activities do you do outside of work?

____

24. Have you ever been hospitalized? No Yes

if yes, why ____

25. Have you had significant past trauma? No Yes

26. Anything else pertinent to your visit today?______________________________

Patient Signature____________________________________ Date:________________