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:**

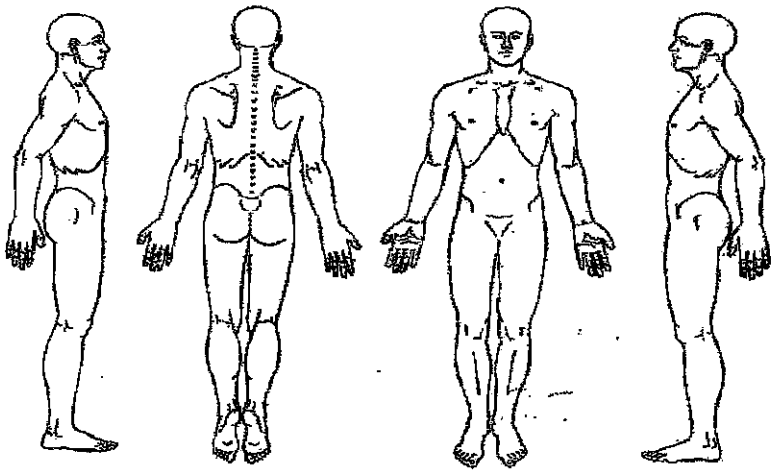
_____

_____

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 ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

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 ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

11. What is your occupation?

_____

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

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

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

Patient Signature _____ **Date** _____

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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		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			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Use Tobacco Products
						☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain				☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite	***Females Only***		
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Birth Control Pills
			☐	☐	Ulcer	☐	☐	Hormonal Replacement
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	
☐	☐	Rheumatoid Arthritis						
			☐	☐	Cancer	***Other Health Problems/Issues***		
☐	☐	General Fatigue	☐	☐	Tumor	☐	☐	Pacemaker
☐	☐	Muscular Incoordination				☐	☐	
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	
☐	☐	Dizziness	☐	☐	Chronic Sinusitis			

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

[redacted]

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

[redacted]

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: _____

HEALTH & PERFORMANCE CENTER

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: _____

Patient Information

HEALTH & PERFORMANCE CENTER

Name: _____
First Middle Initial Last

Date of Birth: _____
Month Day Year

Address: _____
Street City State Zip

Referred By: _____

Contact Information:

Home: (_____)_____ Cell: (_____)_____

Work: (_____)_____ Email: _____

Employer:

Your Employer: _____ Your Position: _____

Employer Address: _____
Street City State Zip

HEALTH &
PERFORMANCE
CENTER

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

Perfect Plan Survey

Name: _____

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

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

Mon & Wed: 7:30am - 11:30am & 2:30pm - 6:00pm

Tue: 11:00am - 2:00pm | Thu: 9:30am - 2:00pm

Fri: 7:30am - 12:00pm

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

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

Not too bad • Starting to affect me • Definitely getting in the way • It is TERRIBLE

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

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

Relief (Pain is relieved)
Relief & Correction (Pain is relieved & cause of pain is addressed
Relief, Correction & Maintenance (Pain can stay away; causative factors are constantly addressed

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

Days • Weeks • Months • Years

6) For some, treatment efficiency and convenience are major concerns. We us TeleCare Rx software to deliver virtual sessions, speeding the recovery process and providing convenience to patients who need it. How interested would you be in this option? (circle one)

Not interested • Somewhat interested • Fairly interested • SIGN ME UP

7) Please provide the following information; a vital component of ensuring an effective care plan

PCP Name: _____ General Location: _____

Office/Group Name: _____ Phone/Email/Website: _____