Confidential Patient Health Record

DATE:	FILE #:

PERSONAL HISTORY

Name_____ **City**_____
Address_____ **State**_____ **Zip**_____
Home phone_____ **Birthday**_____ **Age**____ **Sex: M F**
Cell Phone_____ **Social Security #**_____
Business/Employer_____ **Type of work**_____
Circle one: Married Single Widowed **# of children**___ **Spouse's name**_____
Spouse's Employer_____ **Spouse's Birthday**_____

Name & # of Emergency Contact_____
Referred to this office by_____
Who is responsible for your bill: ( ) Self ( ) Spouse ( ) Insurance

Name of Insurance Company_____

E-mail Address_____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

CONSENT FOR TREATMENT

I the undersigned hereby authorize Dr. Jay Greenberg, D.C. and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs and to administer treatment as is necessary.

I also, certify that no guarantee or assurance has been made to the results that may be obtained. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not treat the patient if he is aware that such care may be contra-indicated. Let the doctor know if any pre-existing defects illnesses or deformities are present.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. 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.

_____ _____
Date Patient's Signature

Patient Health Questionnaire - PHQ

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

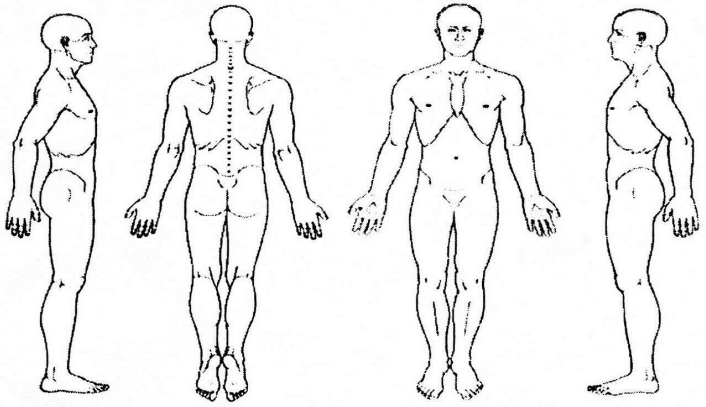
a. When did your symptoms start? _____

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 <u>past 4 weeks</u>:

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 <u>past 4 weeks</u> 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 Health Questionnaire - page 2

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ①None ②Light ③Moderate ④Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.
Feet *Inches*

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*	
○	○	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*	
○	○	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*	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

○ ○ Birth Control Pills
○ ○ Hormonal Replacement

Pregnant
__yes __no __maybe
1st day of last menses
_____
Initial_____

Other Health Problems/Issues

○ ○
○ ○

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*** _____

AUTHORIZATIONS AND RELEASES
Red Wing Chiropractic Clinic
29218 Highway 58 Blvd, Red Wing MN 55066-7407

NAME_____ **FILE #**_____ **DATE SIGNED**_____
WITNESSED BY_____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize that_____Insurance Company/Insurance Administrator to pay by check and for it to be mailed directly to the Red Wing Chiropractic Clinic, 29218 Highway 58 Blvd, Red Wing MN 55066-7407 the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

PATIENT'S SIGNATURE_____

X-RAY/MEDICAL RECORDS RELEASE

I have requested the release of records of (Patient's name)_____which are a part of the records at _____.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them all copies of records and reports including copies of x-rays and photo copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to: Red Wing Chiropractic Clinic, 29218 Highway 58 Blvd, Red Wing MN 55066-7407.

PATIENT'S SIGNATURE_____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. Jay Greenberg, D.C. and whomever may be designated as an assistant(s), to perform diagnostic tests including but not limited to radiographs and to administer treatment as deemed necessary to my (son/daughter). Child's name _____.

GUARDIAN'S SIGNATURE_____

RED WING CHIROPRACTIC CLINIC, P.A.
CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

The Red Wing Chiropractic Clinic is concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of health information entrusted to us.

Ways in which the Red Wing Chiropractic Clinic may use or disclose your health care information include, but are not limited to:

- To another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as an insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control or other operational purposes.
- Business associates that we contract with to perform a service for your benefit and bill for it.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, information about our clinic, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will have access to a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in the clinic facility.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

By signing below, I give consent to the Red Wing Chiropractic Clinic to use my personal health information. It is understood that if I choose not to give consent to use my personal health information, the Red Wing Chiropractic Clinic may refuse to accept me as a patient.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date
_____	
Date	

FOR ACUPUNCTURE PATIENTS ONLY

I, the undersigned, hereby authorize Dr. Jay Greenberg, Doctor of Chiropractic and licensed acupuncturist to perform diagnostic tests and to administer acupuncture treatment as is necessary.

Dr. Greenberg is fully qualified as an acupuncturist as he is certified and registered with the Minnesota Board of Chiropractic Examiners and is licensed by the Minnesota Board of Medical Practice. Dr. Greenberg also has Diplomate Status with the National Certification Commission for Acupuncture and Oriental medicine in Washington, D.C., and has a certificate from the International Academy of Medical Acupuncture.

The scope of practice of acupuncture includes but is not limited to the following.

1. Use of Oriental medical theory to assess and diagnose a patient.
2. Using Oriental medical theory to develop a plan to treat a patient. The treatment techniques that may be chosen include:
    i. insertion of sterile acupuncture needles through the skin;
    ii. acupuncture stimulation including, but not limited to, electrical stimulation or the application of heat.
3. Acupuncture treatment at this clinic may also include dermal friction, acupressure, herbal therapies, dietary counseling, breathing techniques, and exercise according to Oriental medical principles.

You may experience any of the following, however rare during a treatment:

1. slight pain in the treatment area, very minor like a mosquito bite
2. minor bruising, very rare
3. infection; has never occurred at this clinic
4. needle sickness; very rare
5. broken needles; never at this clinic

Please inform the doctor if you have a pacemaker or bleeding disorder.

_____ _____

DATE SIGNATURE