INFORMATION/APPLICATION FOR CARE

The following information is needed to better serve you. Please complete all questions. If you need help, please ask the receptionist. **PLEASE PRINT.**

Today's Date _____

Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Your Employer _____ Occupation _____ Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Your Social Security # _____ Driver's License # _____

Do you have Health Insurance? Yes_____ No_____
If yes: Name of Company_____
Policy #_____ Group # _____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Name of Spouse or Guardian _____ Their Birthdate _____
Spouse Employed By _____ Occupation _____Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Office Phone # _____ Spouse's SS# _____

Emergency Contact: Name of a friend or relative NOT living with you: _____
Address: _____ Phone: _____
Relationship: _____

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Type of Insurance _____Auto _____Workman's Comp _____Health Insurance
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

How did you hear about our office? _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____

INFORMATION/APPLICATION FOR CARE

INSURANCE CASES:

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided that we have prior certification from your insurance company.

2. We accept assignment as a courtesy to you. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

3. Whenever you receive any worksheets from your insurance company, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

4. Any services not covered or coverage reductions by your insurance will be the patient's responsibility as well as all deductible amounts.

5. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

PAST DUE ACCOUNTS:

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Yellowstone County, Montana.

RETURNED CHECKS:

There is a fee (currently $25.00) for any checks returned by the bank.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

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:**

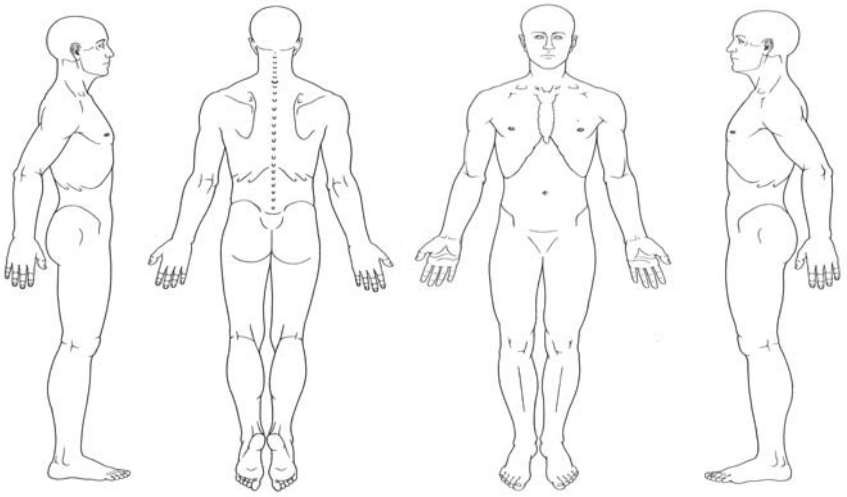
_____

_____

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** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

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

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*	
☐	☐	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
☐	☐	Pregnancy
☐	☐	

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*** _____

SF-12™ Health Survey

ChiroCare Use Only rev 1/29/99

Patient Name _____ ***Date*** _____

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

1. In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
*a. **Moderate activites**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?*	☐	☐	☐
*b. Climbing **several** flights of stairs?*	☐	☐	☐

*3. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?*

	Yes	No
*a. **Accomplished less** than you would like*	☐	☐
*b. Were limited in the **kind** of work or other activities*	☐	☐

*4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?*

	Yes	No
*a. **Accomplished less** than you would like*	☐	☐
b. Didn't do work or other activities as carefully as usual	☐	☐

*5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home, and housework)?*

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

*6. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**....*

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
c. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

*7. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?*

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time