Patient Health Questionnaire

Demographics

Patient Title (check one): □Mr. □Mrs. □Miss □ Dr. □ Prof. □ Rev
First Name: _____ Middle Name: _____
Last Name:_____Suffix: _____
Address: _____
City: _____State: _____ Zip Code: _____
Date of birth: _____ Age: _____
Cell Phone: (_____)_____Home Phone:(_____)_____
Employment Status (circle one): □Employed Full Time □Employed Part Time □Student
□Retired □Self Employed □Other
Email:_____
Marital Status (circle one): □Married □Single □Other: _____
Race (check one): □ White □Black/African American □Hispanic □American Indian □ Alaskan Native □Asian □Asian Indian □ Chinese □ Filipino □ Japanese □ Patient Refused To Specify
Ethnicity (check one): □Hispanic or Latino □ Not Hispanic or Latino □ Refused to Specify
Multiracial (check one): □ Yes □ No □ Unknown
Preferred Language: _____
Current Medications & dosages if known (we can make a copy if you have a list with you):
_____
_____
List any known allergies to medications:
_____
Have you been diagnosed with the following:

- Hypertension: □Yes □No
- Diabetes: □Yes □No if yes, what kind? □Type I □Type II
- Was your blood lab work tested for hemoglobin A1c>9.0%? □Yes □No □Not Sure

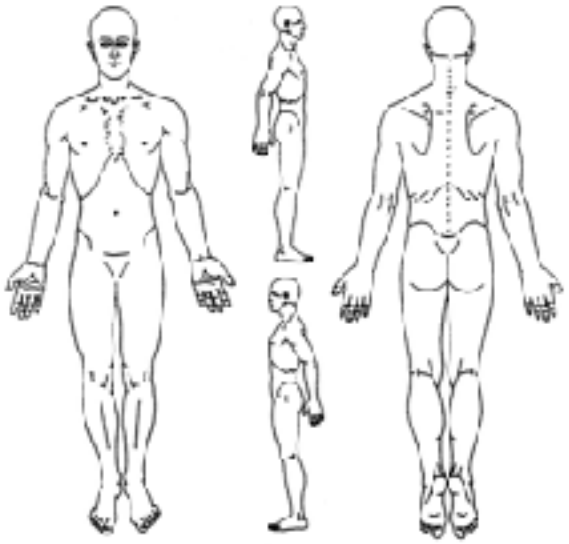
Social History

Do you currently smoke tobacco of any kind? □Yes □Former Smoker □No

- If yes, how often do you smoke? □Current everyday □Current sometimes
- If yes, what is your level of interest in quitting smoking (please circle one)?
  1 2 3 4 5 6 7 8 9 10
  No interest Very Interested

□Coffee: cups/day_____ □Soda: cans/day: _____ □Alcohol: drinks/day _____
□ High stress activity (work or home)
Describe:_____
□Exercise type: _____
□Nutritional Supplements Taken: _____
_____
*Please Indicate where you have pain on diagram

Patient Name: _____ **Date:** _____



1.) Describe your symptoms:

_____

_____

_____

When and how did your symptoms start?

_____

_____

_____

How often do you experience your symptoms (circle one):

□Constantly □Frequently □Occasionally □Intermittently

How are your symptoms changing?

□Getting better □Not Changing □Getting Worse

What describes your pain/symptoms?

□Sharp □Numb □Dull Ache □Shooting □Burning □Tingling

During the past week: Indicate the average intensity of your symptoms (circle one):

(Least) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

How much has pain interfered with your normal work (including both work outside the home and housework)?

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

How many days have you missed work? _____

In general would you say your overall health right now is (circle one)

Excellent Very Good Good Fair Poor

Date of last physical: _____

Have you been treated for any health condition by a physician in the last year? □Yes □No

Who have you seen for your current symptoms?

No one Chiropractor Medical Doctor PT Other

a.) What treatment did you receive from that physician and when?

_____

b.) What imaging have you had for your symptoms and when were they performed?

Brown Family Chiropractic 6232 Bankers Rd Lower Level Mt. Pleasant, WI 53403 Ph:(262)598-0918 Fax:(262)598-0941

Patient Name: _____ **Date: _____**

X-Ray date: _____ MRI date: _____ CT Scan date: _____

Where were these images taken? _____

15.) Do you have any congenital (born with) condition? □Yes □No

(describe)_____

16.) List any surgical procedures you have had and times you have been hospitalized:

_____

_____

17.) List all falls, auto accidents and injuries (even those you thought were not a big deal) and year if known:

_____

_____

FAMILY HISTORY:

Known conditions with relation: _____

_____

_____

Patient Name: _____ **Date:** _____

Review Of Systems:
Please check all that apply:

Constitutional	□Fever □Significant weight change □Significant appetite change	**Urology**	□Frequent urination □Urinary incontinence □Pain with urination □Blood in urine
Eye	□Vision Problems □Eye Irritation □Eye Pain	**Musculoskeletal**	□Joint pain □Joint swelling □Joint stiffness □Low back pain □Neck pain
Ear/Nose/Throat	□Nosebleeds □Cold Symptoms □Voice Changes □Hearing Problems	**Neurology**	□Chronic headaches □Passing out □Confusion □Seizures □Dizziness
Respiratory	□Chronic Cough □Shortness of breath □Wheezing	**Dermatology**	□Rash □Worrisome moles □Skin lesions
Cardiovascular	□Chest pain □Leg swelling □Palpitation (racing heart)	**Mental Health**	□Sadness □Feeling anxious □Chemical dependency
Gastroenterology	□Difficulty swallowing □Heartburn □Abdominal pain □Nausea □Diarrhea □Constipation □Blood in stool	**Endocrinology**	□Feeling too cold or too hot? □Frequently thirsty □Thyroid issues □Immune disorders □Low energy □Hypoglycemia
Male Reproductive	□Prostate issues □Erectile Dysfunction □Infertility	**Hematology - Oncology**	□Swollen glands □Easy bruising
Female Reproductive	□Infertility □PMS symptoms □Low libido		

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this consent form, discuss it with your clinician if you'd like to, and then sign where indicated at the bottom.

Clinicians who use spinal manual therapy techniques, such as, joint adjustment, manipulation or mobilization, or required to inform patients that there are or may be some risks associated with such treatment. In particular:

A. While rare, some patients have experienced muscles and ligaments sprains or strains, or rib fractures following spinal manual therapy.
B. There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.
C. There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than your risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes. it is the responsibility of the patient to make it known whatever she/he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic.

Your clinician will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and any treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis, and extremities (shoulder, upper limbs, and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Print name: _____ Signature:_____

Guardian Name: _____Guardian Signature:_____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in the office and your rights concerning those records. Before we will begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or Companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services or charitable work performed by our office. you may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. patients have the right to file a formal complaint with our privacy official and the Security of HHS about any posible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. you will be provided with the new notice at your next visit following the change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment healthcare operations, the chiropractic physician has the right to refuse to give care.
11. I authorize Brown Family Chiropractic, LLC to bill my insurance company and asking payment of benefits directly to the office of Brown Family Chiropractic, LLC.

I have read and understand how my Patient Health Information will be used and I agree to those policies and procedures.

Name of Patient: _____Date: _____

Signature of Patient:_____