WELCOME

1 ABOUT YOU

Today's Date: ______ /______ /________

Patient Name: ____
LAST FIRST MI

What you prefer to be called: ________________ • •Male • •Female

Birthdate: ______ /______ /______ Age: ______ SS#: ________

Mailing Address: ____

____
CITY STATE ZIP

Home Phone: (______) ________________________

Work Phone: (______) ________________________

Cell Phone: (______) ________________________

E-mail Address: ________________________________

Referred By: ________________________________

Employer: ________________________ How Long? ______

Employer's Address: ________________________________

____
CITY STATE ZIP

Occupation: ________________________________

Status: • •Minor • •Single • •Married • •Divorced • •Separated • •Widowed

Spouse's Name: ________________________________

Do you have children? • •Yes • •No How many? ________

2 INSURANCE INFO

Primary Insurance

Co. Name: ________________________________

Address: ________________________________

____
CITY STATE ZIP

Phone: (______) ________________________

Insured's ID# ________________________________

Group # (Plan, Local or Policy #) ________________

Insured's Name: ________________________________

Relation: ________ Date of Birth: _____ /_____ /_____

Insured's Employer: ________________________________

Secondary Insurance

Co. Name: ________________________________

Address: ________________________________

____
CITY STATE ZIP

Phone: (______) ________________________

Insured's ID#: ________________________________

Group # (Plan, Local, or Policy #): ________________

Insured's Name: ________________________________

Relation: ________ Date of Birth: _____ /_____ /_____

Insured's Employer: ________________________________

3 ACCOUNT INFO

Person ultimately responsible for account

Name: ________________________________

Relation: ________________________________

Billing Address: ________________________________

____
CITY STATE ZIP

SS # ________________________________

Drivers License # ________________________________

Work Phone: (______) ________________________

Payment Method: • •Cash • •Check

________________________________ _____ / _____

• •Credit Card – Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and
Initials benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at his office).

4 IN EVENT OF EMERGENCY

Whom should we contact? ________________________________

Relation: ________________________________

Home Phone: (______) ________________________

Work Phone: (______) ________________________

Cell Phone: (______) ________________________

Who is your Medical Doctor? ________________________________

Medical Doctor's Phone: (______) ________________________

Signature________________________________ Date__________

Duluth MultiCare, Inc.

3170 Peachtree Industrial Blvd. • Suite 170 • Duluth, GA 30097

Phone: 770-497-9700 • Fax: 770-497-0795

Patient Health Questionnaire - PHQ

Patient Name: ______________________________ Date ______________

1. Describe your symptoms: ______________________________

____

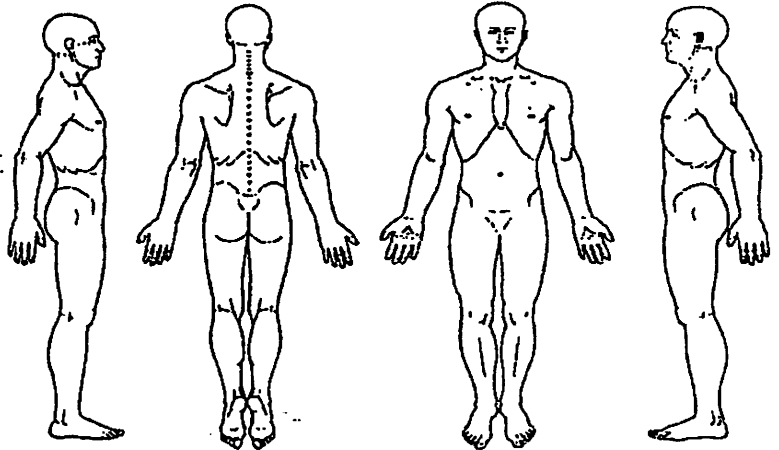
____

a. When did your symptoms start? ______________________________

b. How did your symptoms begin? ______________________________

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



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 and inside 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

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 ② Self-employed ③ Unemployed ⑤ Off work ⑥ Other

Patient Signature ______________________________ **Date** ______________

HEALTH HISTORY

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s)

Do you have or have you had any of the following disease, medical conditions or procedures?

☐ Heart Attack/Stroke ☐ Heart Surg./Pacemaker ☐ Frequent Neck Pain ☐ Congenital Heart Defect ☐ HIV+ / AIDS / ARC
☐ High/Low Blood Pressure ☐ Alcohol / Drug Abuse ☐ Rheumatic Fever ☐ Severe/Frequent Headaches ☐ Anemia / Diabetes
☐ Ulcers/Colitis ☐ Cancer ☐ Sinus Problems ☐ Emphysema / Asthma ☐ Kidney Problems
☐ Difficulty Breathing ☐ Psychiatric Problems ☐ Lower Back Problems ☐ Artificial Bones/Joints/Implants ☐ Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: ____________________

____

Please list anything that you may be allergic to: ____________________

Family Health History: ☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Obesity

Do you take Supplements or Vitamins ☐ Yes ☐ No Do you exercise? ☐ No ☐ Yes ______ hours per week

Do you smoke? ☐ Yes ☐ No How much? ____________________ How long? __________

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports Are you dieting: ☐ No ☐ Yes Since ______ / ______ / ______

For women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ No ☐ Yes If so, how many weeks? __________

Describe your energy level:

☐ Energetic all day ☐ Energetic am; tired pm ☐ Tired am; energetic pm ☐ Periodic dips in energy throughout day ☐ Low energy all day

Describe your daily non-exercise activity level:

☐ very sedentary ☐ light activity ☐ moderately active ☐ very active

How many fruits and vegetables do you eat daily? ________ Fruits ________ Vegetables

Do you exercise at least 3 times per week for 30 minutes or more? ☐ Yes ☐ No

How many 8-ounce glasses of water do you drink daily? __________

Are you currently taking any vitamin supplements? Please list below.

# Per Day	Vitamin/Supplement and Brand (List all that you are currently taking)

☐ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

☐ Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager.

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or other medical/legal services engaged on my behalf.

☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

☐ Parent or Guardian: I authorize the staff to administer treatment as deemed necessary for my ____________________
Indicate Relationship

Signature ______________________________ Date ______ / ______ / ______

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ____________________ , understand that as part of my health care, Duluth MultiCare originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Duluth MultiCare is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Duluth MultiCare reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should____________ __________________________ change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:____________________

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

____ ____________________

Patient's Signature (authorized representative signing for the patient) Date

FOR OFFICE USE ONLY

- ☐ Consent received by ____ on ______________
- ☐ Consent refused by patient, and treatment refused as permitted.
- ☐ Consent added to the patient's medical record on ____

TPO CONSENT