Patient Information

1. First Name: _____ Last Name: _____ DOB: _____

2. MRN #: _____

PATIENT INTAKE

ABOUT YOU

3. Home Address

Address 1 _____ Address 2 _____

City _____ State _____ Zip Code _____

4. Contact Information

Mobile Phone _____ Home Phone _____

Primary Email Address _____

5. Demographic Information

Sex at birth:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed ○ Other

6. Emergency Contact Information

Emergency Contact Name: _____ Contact Phone Number: _____ Relationship to Patient: _____

7. Employer Information

Employment Status:
○ Employed ○ Student ○ Not Employed ○ Retired ○ Unknown

Employer Name: _____ Occupation: _____

Physical Work Duties: _____

8. **Referral Information**

Referring Physician: _____ Referring Patient: _____

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other: _____

9. Number of Children: _____

10. **Personal Information**

Height - Feet: _____ Height - Inches: _____

Weight (in pounds): _____

11. **Spouse's Name:** _____

12. **Do you have insurance?**

○ Yes ○ No

13. **Insurance Payer**

Insurance Payer _____

14. **Insurance Policy Information:**

Insurance Plan Name _____ ID/Policy Number: _____ Group Number: _____

Relationship to Patient:

○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: _____ Insured's Date of Birth: _____

15. **Insurance Card Upload**

VISIT PURPOSE

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

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

Patient Name ***Date***

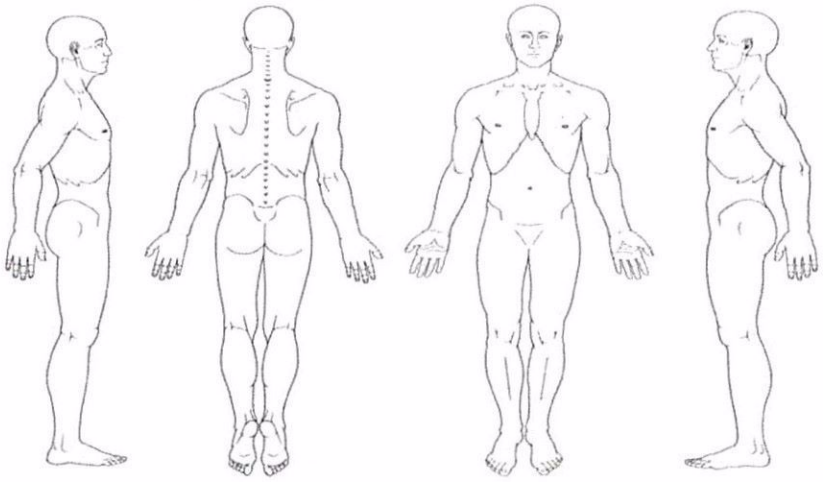
1. When did your symptoms start:

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? BP: / 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
☐	☐	Pregnancy
☐	☐	

Other Health Problems/Issues

☐	☐	
☐	☐	
☐	☐	

How many meals do you eat a day: ____

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 Recent: Injuries, Illnesses, Accidents

_____

Any cognitive troubles or memory problems:

_____

Doctors Signature _____ ***Date*** _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working at associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, stroke, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor or staff:

Gravon's Natural Chiropractic Center
1024 Oxford St
Worthington, MN 56187

Name of Doctor(s) treating this patient:

Dr. Janine Bremer

GRAVON'S NATURAL CHIROPRACTICE CLINIC FINANCIAL INFORMATION

The purpose of this information is to clarify your financial responsibilities.
We can then devote our efforts to helping you get the best results in the shortest amount of time.
These are the most common services we provide and when they are performed.

Procedure	Purpose	When Performed
Consultation	Tour the office, meet the doctor, discuss your health problem, and review your case history.	First visit.
Evaluation/Management [Examination(s)]	Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine an appropriate course of action.	First visit, new conditions, exacerbations, and re-examinations.
X-Rays	Visualize the location of spinal problems and confirm other examination findings.	If necessary, first visit, re-injuries, and at certain progress examinations.
Adjustment	Reduce the Vertebral Subluxation Complex and help stabilize your spinal or joint problem.	As indicated by examination or evaluation.
Therapy	Reduce inflammation and swelling, speed the healing process, and help provide relief.	As indicated by examination or evaluation.

- **Forms of Payment**

Patients are responsible for full payment at the time of service. We accept cash, personal checks, VISA and Mastercard. Any credit arrangements must be authorized in advance.

- **Insurance/Contract Services/Third Party**

Other options are available if group health insurance, worker's compensation, a managed care provider, Medicare, personal injury, or the result of an auto accident covers your care.

All professional services are rendered and charged to the patient receiving care and not to an insurance provider. We will supply you with statements, reports, or other documents to help you receive reimbursement from a third party. We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information.

- **Billing**

Any outstanding balances are billed monthly and considered past due 10 days after the invoice date or when special arrangements are not met. Returned checks are subject to a $15.00 fee. Balances older than 30 days will accrue interest charges of 1.5% per month, plus any legal or collection fees.

Patient Agreement

I have read, understood, and agreed to this agreement.

_____ _____
Patient/Responsible Party Signature *Date*

Questions

Please ask if you have questions about this agreement or your ability to comply with its provisions. We are here to help.

_____ _____
Patient/Responsible Party Signature *Date*

Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions contained to be irrevocable. I fully understand that I am directly responsible for all medical chiropractic bills and this arrangement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's Signature _____ **Date** _____ Witness _____

Form 23005

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

NAME OF INDIVIDUAL: _____

This is to acknowledge receipt of a copy of Gravon's Natural Chiropractic Center's Notice of Privacy Policy with an effective date of 4-4-03.

Individual's (or Legal Representative's) Name: _____

Individual's (or Legal Representative's) Signature: _____

Date: _____

Capacity of Authority of Legal Representative (if applicable)*: _____

*May be requested to provide verification of representative status.

For office use only

We made the following efforts for obtain written acknowledgement of receipt of the Notice of Privacy Practices

_____

_____

_____

_____

However, acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify):

_____

_____

_____