Heuser Chiropractic
144 W. 32nd Street, Yuma AZ 85364
928.726.8847, Fax 928.341.0417

PATIENT INFORMATION FORM

Full Name _____ Date _____

Address _____ Apt City _____ State Zip _____

Home Phone _____ Work Phone _____ Ext _____

Email Address _____ Cell Phone _____

Date of Birth _____ Sex Marital Status Spouse's Name _____

Occupation _____ Children (Ages) _____

Employer _____ Employer Address _____

Social Security # _____ Drivers License # _____ State _____

How did you hear about our office? _____

Name of personal physician _____

Nearest relative not living with you, (emergency contact) _____

Relationship _____ Phone _____ Address _____

Who is responsible for this account? _____

Type of payment you plan to use, (circle), Insurance / Cash / Credit Card / Other _____

ACCIDENT-INJURY INFORMATION

Are your present problems due to an accident or injury _____ Date of accident or injury _____

Type of accident/injury, (circle): Auto/On-the-job/Sports/Military/Household/Slip & Fall/Personal/Other _____

Name of Attorney handling your case _____ Phone # _____

INSURANCE INFORMATION

Type of insurance you plan to use to help pay your account, (circle): Auto/Work Comp/Group/Medicare/Other _____

Name of Insurance Company _____ Phone # _____

Insured's Name/Date of Birth _____ ID # _____ Group # _____

If insurance is your spouses please list spouses employer: _____

TREATMENT AUTHORIZATION

I hereby authorize this office and its staff and doctors to examine and treat me or my above mentioned dependents condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me or my de- pendent are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my or my dependents behalf. Should collection of a past due amount become necessary. I will become responsible for all charges, fees and attorney fees. All charges for services and care given will be charged directly to me and I will be responsible for payment of them. I give my permission to be called by telephone concerning my or my dependents appointments or treatment, even if my name and number are on a state or national no call list. Please also be aware we do use audio and video recording throughout this office.

We realize today's free spinal examination includes, but is not limited to a consultation, history of the complaint and examination/palpation of the area involved to determine if there is a need for chiropractic care. However, the free screening does not include x-rays or treatment and is limited to one free exam per individual. If x-rays are indicated it is customary to pay for x-rays when taken unless deposit arrangements are made in advance. We are required by Law to advise you of the fees for our services. They are as follows: X-ray views 8x10 $30.00 each; 14x17 view $45.00 each; copies of x- rays $10.00; Spinal Manipulations $45.00. All therapies are $30.00 except for Decompression which is $65..00, Posture Pump $30.00 and each rehab area and re-exams are $40.00 each. Please rest assured our staff/manager will review all charges before treatment is administered. I have received a copy of the "Notice of Privacy Practices" for me to keep for my records.

Patient/Guardian Signature (x) _____ Date _____

PREVIOUS HEALTH PROBLEMS

Fractured bones	Spinal Taps	Fainting	Are you pregnant Y N
Allergies	Scoliosis	Birth defects	
Joint replacement	Diabetes	Osteoporosis	
Metal screws/implants	High Blood Pressure	Cancer	Other serious illness:
Cervical whiplash	Stroke	Tumor	_____
Electronic implant	Aneurysm	Cyst	_____
Pacemaker	Convulsions	Ear infections	_____
Ruptured spinal disc	Seizures	Birth complications	_____
Slipped spinal disc	Memory Lapse	Asthma	
Pinched nerve	Dizziness	Bed wetting	
Spinal surgery	Concussion	Heart disease	
Spinal injections	Arthritis	Fibromyalgia	
Thyroid problems	Bowel/bladder changes	Menstrual	
Endometriosis	Pelvic pain	Shoulder pain	

Surgeries _____

_____

_____

SURVEY

In order that we can improve our services to better suit your needs, we ask that you take a few minutes to an- swer the following questions:

DO YOU...

Have tired, achy feet/legs	Y	N	Have a "high arch"?	Y	N
Have heel pain?	Y	N	Have toe pain/numbness?	Y	N
Have pain at the ball of your	Y	N	Have knee pain?	Y	N
Have uneven footwear?	Y	N	Have hip pain?	Y	N
Have "flat feet"?	Y	N	Lower back pain?	Y	N

If you have answered YES to one or more of the above questions, we recommend that you take this opportunity to have a free knee/foot care consult with one of our Doctors! You may be a candidate for Orthotics or Orthopedic footwear!

We here at Heuser Chiropractic believe strongly in maintaining and improving the health of your feet!

Patient Initials _____

PATIENT HEALTH QUESTIONNAIRE- PHQ

Patient Name _____ Date: _____

1. Describe your symptoms: _____

_____

_____

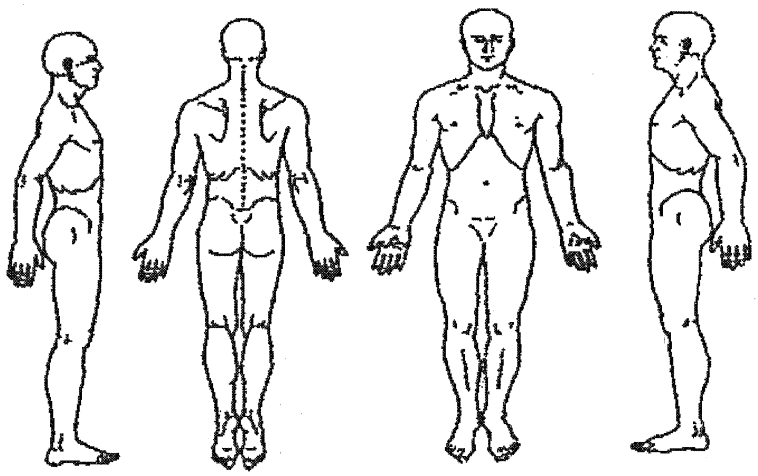
a. When did your symptoms start? _____

_____

b. How did your symptoms start? _____

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 <u>past 4 weeks</u>: None Unbearable

a. Indicate the average intensity of your symptoms 0 1 2 3 4 5 6 7 8 9 10

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 past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with your friends)

1. All the time 2. Most of the time 3. Some of the time 4. A little bit 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 3. Medical Doctor 5. Other
2. Other chiropractor 4. Physical Therapist

a. What treatment did you receive and when? _____

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

1. X-rays - 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 3. Medical Doctor 5. Other
2. Other chiropractor 4. Physical Therapist

10. What is your occupation?

1. Professional/Executive 4. Laborer 7. Retired
2. White collar/Secretarial 5. Homemaker 8. Other
3. Trades person 6. FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

1. Full-time 3. Self-employed 5. Off work
2. Part-time 4. Unemployed 6. Other

Patient Signature _____ Date _____