Patient Information

☐ New Patient

☐ Update Only

PLEASE NOTIFY THE RECEPTIONIST IF YOU ARE HERE FOR A WORKERS COMPENSATION CASE OR IF YOU WERE INVOLVED IN A MOTOR VEHICLE ACCIDENT.

Your Name _____ Birth Date _____ Age _____

Address _____ Sex M___F___ # Children _____

_____ Marital Status M___D___S___W___

City State Zip

Cell Phone # _____ Cell Carrier _____

Please include area code (For appointment reminders)

Home# _____ Social Security # _____

Please include area code

Email _____

Employer _____ Occupation _____

Insurance Co. _____ ID# _____

Subscriber Name _____ DOB _____

If other than patient

Spouse/Parent name _____ Phone# _____

Responsible Party Self_____Spouse_____Parent_____Other_____

Emergency Contact _____ Phone# _____

How did you hear about us? _____

Authorization and Assignment I authorize you to release any information necessary to process claims and I assign to the physicians all payments for medical services. I understand that I am ultimately reponsible for payment, regardless of insurance coverage. This authorization is valid until revoked in writing.

Signature _____ Date _____

McMahon Chiropractic Clinic 1170 Molalla Ave. Oregon City OR 97045 (503) 656-9877

Patient Health Questionnaire

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

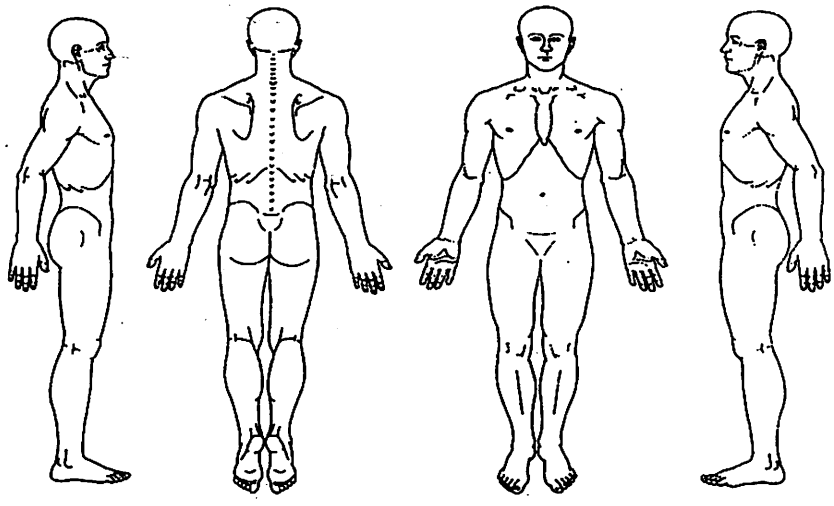
_____

_____

2. How often do you experience your 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)

Indicate where you have pain or other symptoms



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. 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?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. When and what treatment? _____

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

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. 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

11. What is your occupation?

_____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson 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

12. What do you hope to get from your visit/treatment *(select all that apply)*:

① Reduce symptoms ③ Explanation of condition/treatment ⑤ How to prevent this from occurring again
② Resume/increase activity ④ Learn how to take care of this on my own ⑥

Patient Signature _____ **Date** _____

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Patient Health Questionnaire - page 2

American Chiropractic Network

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Patient Name _____ **Date** _____

What type of regular exercise do you perform? ①None ②Light ③Moderate ④Strenuous

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		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke			
O	O	Low Back Pain	O	O	Angina	O	O	Smoking/Use Tobacco Products
						O	O	Drug/Alcohol Dependence
O	O	Shoulder Pain	O	O	Kidney Stones			
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders	O	O	Allergies
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Depression
O	O	Hand Pain	O	O	Painful Urination	O	O	Systemic Lupus
			O	O	Loss of Bladder Control	O	O	Epilepsy
O	O	Hip/Upper Leg Pain	O	O	Prostate Problems	O	O	Dermatitis/Eczema/Rash
O	O	Knee/Lower Leg Pain				O	O	HIV/AIDS
O	O	Ankle/Foot Pain	O	O	Abnormal Weight Gain/Loss			
			O	O	Loss of Appetite	***Females Only***		
O	O	Jaw Pain	O	O	Abdominal Pain	O	O	Birth Control Pills
			O	O	Ulcer	O	O	Hormonal Replacement
O	O	Joint Swelling/Stiffness	O	O	Hepatitis	O	O	Pregnancy
O	O	Arthritis	O	O	Liver/Gall Bladder Disorder	O	O	
O	O	Rheumatoid Arthritis						
			O	O	Cancer	***Other Health Problems/Issues***		
O	O	General Fatigue	O	O	Tumor	O	O	
O	O	Muscular Incoordination				O	O	
O	O	Visual Disturbances	O	O	Asthma	O	O	
O	O	Dizziness	O	O	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O _____

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** _____

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Neil McMahon, R.N., D.C., P.C. Andy Beutz D.C Holly Beutz D.C.

OFFICE FINANCIAL POLICY

FOR PATIENTS WITHOUT INSURANCE

_____ Payment is expected at the time of treatment. If other arrangements are necessary, please inquire. We are happy to accept cash, checks, Visa, MasterCard, Discover or American Express. We offer a 20% billing discount if all services are paid in full at the time of treatment.

FOR PATIENTS WITH INSURANCE

_____ There have been a lot of recent changes with health insurance. Even if you have not changed insurance companies, there may have been changes made to your existing plan. Your plan may have a different copay, deductible, or coverage maximum. As a courtesy to you we verify your insurance benefits. Once we have obtained this information from your insurance company, we relay this information to you. However, a quote of benefits is not a guarantee that services will be paid for. It is important for you to understand that any insurance you have is an agreement between you and your insurance company. **All charges not covered by your insurance company are your responsibility.**

If you believe that any of the information we were given regarding your insurance benefits was incorrect, we encourage you to contact your insurance company, to verify your benefits yourself. We are happy to provide you with a form, with all of the questions you need to ask, to fully understand your chiropractic benefits. If we were given any incorrect information, please let us know.

FOR PATIENTS WITH MEDICARE

_____ We accept Medicare assignment. We will bill Medicare on your behalf. Medicare covers spinal manipulation only, but does not cover an exam or therapies. All services other than the spinal manipulation will be your responsibility and payment will be expected at the time of service.

FOR AUTOMOBILE ACCIDENTS OR PERSONAL INJURY

_____ Automobile insurance and personal injury does cover chiropractic care. Please provide **your** auto insurance information at your first visit. If at any time your insurance stops paying for your care, all subsequent visits will require payment at the time of service. If necessary, payment arrangements can be made. See our billing staff for any questions. If an attorney is handling your case, please notify our billing staff as soon as possible.

"ON THE JOB" INJURY

_____ Workers' compensation laws allow limited chiropractic care for documented work injuries. Please be sure to notify your employer and fill out the appropriate forms. We will be happy to bill your workers' compensation insurance carrier and work within the guidelines of the workers compensation laws.

I have read the above financial policy and have initialed the section that applies to me. I understand the terms as stated above.

_____ _____

Signature Date