WELCOME TO
Date: _____

BEE CAVES CHIROPRACTIC
& SCOLIOSIS CENTER

How did you hear about us? _____

Patient Information

First & Last Name: _____

Address: _____

City: _____ St: ____ Zip: _____

Home Phone: _____ Cell Phone: _____
Work Phone: _____ ext: _____

Email Address: _____

Sex ( )M ( )F Age: ____ Date of Birth: _____

( ) Single ( ) Married ( ) Divorced ( ) Widowed

Insurance Information

We will gladly file your medical insurance for you!
Please provide us with a copy of your insurance card so that we may obtain the information needed to properly file the insurance. You will be responsible for remaining balances and any fees if account goes to collections.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document gives full authorization to my physician to submit claims for benefits, for services rendered.

Signature: _____ Date: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

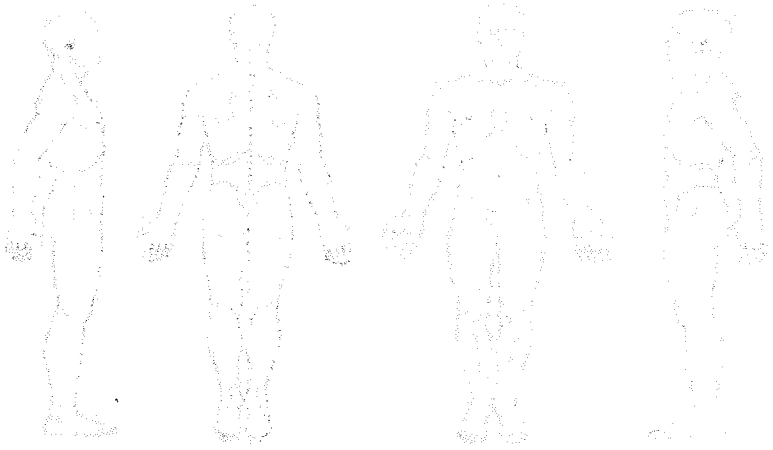
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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. 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 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 ③ Medical Doctor ⑤ Other
② 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 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 ③ Medical Doctor ⑤ Other
② 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 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

Patient Signature _____ **Date** _____

BEE CAVES CHIROPRACTIC
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MEDICAL HISTORY

For

_____
(Patient Name)

Have you ever had any of the following?

__Congestive Heart Disease
__Heart Attack or Chest pain
__High Blood Pressure
__Stroke
__Chronic Lung Disease
__Cancer
__Emphysema
__Diabetes
__Ulcer or Bleeding Bowels
__Arthritis or Rheumatism
__Kidney or Bladder Disease

Do you now have any of the following?

__Recent Unexplained Weight Loss
__Fevers or Chills at Night
__Fatigued throughout the day
__Constantly hungry
__Loss of bowel or bladder control
__Rapid Heart Beat or Breathing
__Depression
__Osteoporosis or osteopenia

Have you had any of the following? (related to your symptoms today)

Surgery: _____ **Accidents or Falls:** _____
Broken Bones: _____ **Car Accidents:** _____

Current Medications:

_____

Tobacco use:
__Do not Smoke __ Less than ½ Pack __1/2-1 Pack
__1-2 Packs __More than 2

PATIENT SIGNATURE: _____ **Date:** _____