



Patient confidentiality Personal Data

Date_____

Patient:_____Date of Birth:_____

Home Address:_____City:_____State:_____Zip_____

Cell Phone:_____Home Phone:_____Work Phone:_____

May we contact you at work? Yes___No___May we contact you at home? Yes___No___

SSN #:_____Employer:_____

Marital Status: Single Married Divorced Widowed

Name of Spouse:_____Number of Children_____

How were you referred to our clinic?_____

Emergency Contact:_____Phone Number:_____

Who is responsible for payment? Self Spouse Insurance Other

Insurance Carrier(if applicable):_____

E-mail Address_____

By providing your e-mail address you will receive our E health letters, specials and announcements.
(Approximately 1 e-mail per month; your e-mail address is strictly used for our office only.)

Patient Health Questionnaire

Name _____

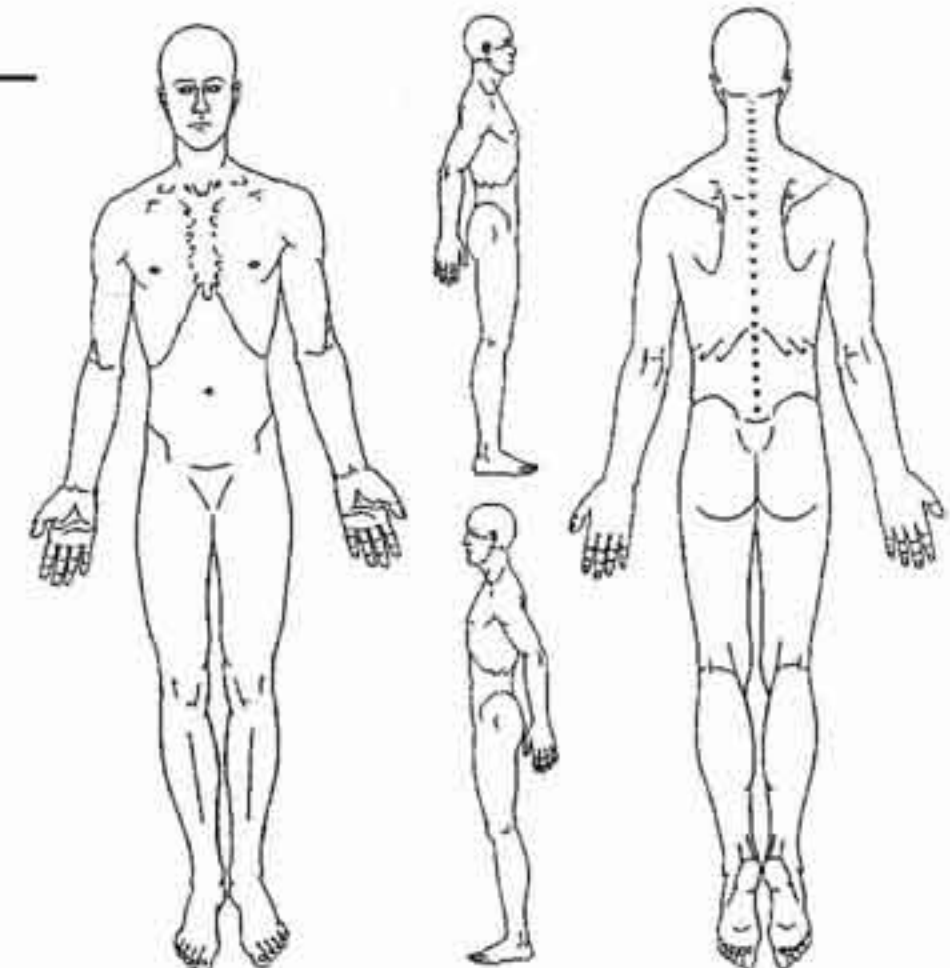
In the space below, please describe your major complaint.

1. Please Describe Your Complaint(s): _____

- a. Description
- Sharp Pain
 - Dull Pain
 - Ache
 - Weak
 - Throbbing
 - Numb
 - Shooting
 - Gripping
 - Burning
 - Tingling

- b. Frequency
- Constant (76-100%)
 - Frequent (51-75%)
 - Occasional (26-50%)
 - Intermittent (25% or less)

**MARK ON THE PICTURE
WHERE YOU HAVE PAIN
OR OTHER SYMPTOMS.**



c. Indicate intensity of your pain at its lowest and highest level No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

d. Your symptoms are Decreasing Not Changing Increasing

e. Symptoms are worse in Morning Afternoon Increases During the Day Same All Day

2. When did your problem begin? (specific date if possible) _____ Describe how your problem began _____

3. Have you been treated for **this episode**? yes no

If yes, by whom? Chiropractor MD Osteopath Physical Therapist Occupational Therapist Other _____

Are you currently being seen? yes no

When and what treatment? _____ / _____ / _____

4. **In the past** have you been treated for a same or similar problem? yes no

If yes, who did you see for that episode? Chiropractor MD Osteopath Physical Therapist Occupational Therapist Other _____

When and what treatment did you receive? _____

5. What makes your problem better? Nothing Lying Down Walking Standing Sitting Movement/Exercise Inactivity

6. What makes your problem worse? Nothing Lying Down Walking Standing Sitting Movement/Exercise Inactivity

7. What would you rate your general stress level? Little or no stress Minimal stress Moderate stress Greatly stressed

8. General Physical Activity: No regular exercise Light exercise program Moderate exercise program Strenuous exercise program

9. Are your complaints affecting your ability to be active?

- No affect Some physical restrictions (able to perform light duty work and household tasks)
- Need limited assistance with common everyday Need assistance often
- Have a significant inability to function without assistance Am totally disabled (impaired), cannot care for self

10. Physical activity at work: Sitting more than 50% of workday Light manual labor Heavy manual labor Repeated motion

11. Occupation: _____ FT PT Has your work status changed because of this complaint? Yes No

12. What is your current work status?

- Full time, no restrictions Part time, with restrictions Unemployed Other _____
- Full time, with restrictions Off work due to restrictions Retired
- Part time, no restrictions Full time homemaker Full time student

(CONFIDENTIAL)

If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

PATIENT HEALTH QUESTIONNAIRE

Past Present Neck Pain (723.1) Shoulder Pain (719.41) Pain in Upper Arm or Elbow (719.42) Hand Pain (719.44) Wrist Pain (719.43) Upper Back Pain (724.1) Low Back Pain (724.2) Pain in Upper Leg or Hip (719.45) Pain in Lower Leg or Knee (729.5) Pain in Ankle or Foot (719.47) Jaw Pain (526.9) Swelling/Stiffness of Joint Fainting (780.2) Visual Disturbances (368.9) Convulsions (780.3) Dizziness (780.4) Headache (784.0) Muscular Incoordination (781.3) Tinnitus (Ear Noises) (388.30) Rapid Heart Beat (785.0) Chest Pains (786.50) Loss of Appetite (783.0) Anorexia (307.1) Abnormal Weight Excessive Thirst (783.05) Chronic Cough (786.2) Chronic Sinusitis (473.9) General Fatigue (780.7) Irregular Menstrual Flow (626.04) Profuse Menstrual Flow (626.7) Breast Soreness/Lumps (611.72) Endometriosis (617.9) PMS (625.4) Loss of Bladder Control(788.30) Painful Urination (788.1) Frequent Urination (788.41) Abdominal Pain (789.0) High Blood Pressure Constipation/Irregular bowel habits (564.0) Difficulty in Swallowing (787.2) Heartburn/Indigestion (787.1) Dermatitis/Eczema/Rash (692.9) Depression (311)

Past Present Aortic Aneurysm (441.50) High Blood Pressure (401.9) Angina (413.9) Heart Attack (410.9) Stroke (435) Asthma (493.9) Cancer (199.1) Tumor (229.9) Prostate Problems (601.9) Blood Disorder (790.6) Emphysema (chronic lung disorder) (526.9) Arthritis (716.9) Rheumatoid Arthritis (714.0) Diabetes (250.0) Epilepsy (349.5) Ulcer (556.9) Liver (573.9)/Gallbladder (575.9) problems Kidney Stones (592.0) Hepatitis (573.3) Bladder Infection (595.9) Kidney Disorders (by condition) Colitis (558.9) Irritable Colon (564.1) HIV/AIDS (042) Systemic Lupus Other _____

If a family member has had any of the following please mark the appropriate box.

Cancer Epilepsy Rheumatoid Arthritis Chronic Back Pain Diabetes Chronic Headache Heart Problems Lupus Lung Problems Other Conditions _____ High Blood Pressure _____

Yes No Do you have a permanent disability rating? Location _____ Date rating received ____/____/____ Rating Percentage _____%

Please check any of the following that apply to you.

Past Present Pregnancy (V22.2) Birth Control Pills Hormonal/Estrogen Replacement Medications (list if not listed elsewhere) _____ Hospitalization/Surgical Procedures (list if Not described elsewhere) _____

Past Present Tobacco (305.1) Alcohol (305.0) Drug or Alcohol Dependence (303.9) Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day _____

Present Weight _____ pounds Height _____ feet _____ inches

Patient's Signature: _____ Date: _____

Doctor's Additional Comments/General Health Concerns

Financial Office Policy

Patients Without Insurance:

1. 100% of the first visit is to be paid in full at time services are rendered
2. For your Convenience, our office accept cash, checks, Visa/MC, Discovery.

Patients With Insurance:

1. After verification of your coverage, we will accept payments directly from your carrier. (this will save you from paying the total charges in full as services are rendered).
2. Patients are responsible for all Uncovered Services at the time of visit, (i.e. deductible, co-insurance).
3. Patients must stay current with their co-insurance payments.
4. **Your insurance is an agreement between YOU and your insurance company. Therefore, this clinic does not promise that you insurance company will pay the charges and will not enter into a dispute with the insurance company over reimbursement. If your carrier denies a payment, the patient is personally responsible for payment. Verification of coverage is not a guarantee of payment for services rendered.**
5. If you have secondary insurance we will provide the claim for you to process.
6. When all insurance checks have been received, if there is overpayment, we will credit this to your account.
7. Our office gives an insurance company 90 days from an incurred charge to pay their portion. If for any reason they do not pay in 90 days, then the balance becomes the patient's responsibility and is due and payable at that time.
8. The patient is responsible for any and all attorney fees for collection of past due accounts.

Wellness/maintenance patients

- Those being treated on a monthly basis must pay at the time of treatment.

There will be no additional charges for appointments rescheduled 24 hours in advance.

I agree to the above listed terms set forth by the chiropractic office of Dr. Noe Flores.

Signed _____ Date _____