

WELCOME

1

ABOUT YOU

Today's Date: _____ / _____ / _____

Patient Name: _____
LAST FIRST MI
What you prefer to be called: _____ Male Female

Birthdate: _____ / _____ / _____ Age: _____ SS#: _____

Mailing Address: _____

CITY STATE ZIP
Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP
Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

2

INSURANCE INFO

Primary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP
Phone: (_____) _____

Insured's ID# _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____

Relation: _____ Date of Birth: _____ / _____ / _____

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP
Phone: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____ / _____ / _____

Insured's Employer: _____

3

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP
SS # _____

Drivers License # _____

Work Phone: (_____) _____

Payment Method: Cash Check

_____ / _____

Credit Card – Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and
Initials benefits directly to the provider for services rendered. I fully
understand I am solely responsible for any balance not paid by my
insurance company (if offered at his office).

4

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone: (_____) _____

Signature _____ Date _____

Duluth MultiCare, Inc.

3170 Peachtree Industrial Blvd. • Suite 170 • Duluth, GA 30097
Phone: 770-497-9700 • Fax: 770-497-0795

Patient Health Questionnaire - PHQ

Patient Name: _____ Date _____

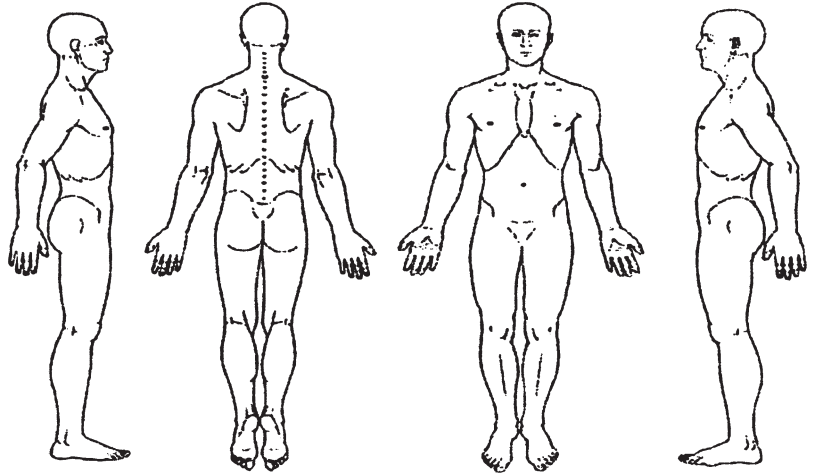
1. Describe your symptoms: _____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? 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
- ② Dull Ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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 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 and inside 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
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms

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

9. Have you had similar symptoms in the past?

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① Yes
- ② No
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

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

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other
- ⑨ Full-time
- ⑩ Part-time
- ⑪ Self-employed
- ⑫ Unemployed
- ⑬ Off work
- ⑭ Other

Patient Signature _____ Date _____

HEALTH HISTORY

Are you taking any of the following medications? Nerve pills Pain killers (including aspirin)
 Muscle relaxers Blood thinners Tranquilizers Insulin Other(s)

Do you have or have you had any of the following disease, medical conditions or procedures?

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Heart Surg./Pacemaker | <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> HIV+ / AIDS / ARC |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Anemia / Diabetes |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Emphysema / Asthma | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Artificial Bones/Joints/Implants | <input type="checkbox"/> Arthritis |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

Please list anything that you may be allergic to: _____

Family Health History: Diabetes Heart Disease Cancer Obesity

Do you take Supplements or Vitamins Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? Yes No How much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since _____ / _____ / _____

For women: Are you taking Birth Control? Yes No

Are you Pregnant? No Yes If so, how many weeks? _____

Describe your energy level:

- Energetic all day Energetic am; tired pm Tired am; energetic pm Periodic dips in energy throughout day Low energy all day

Describe your daily non-exercise activity level:

- very sedentary light activity moderately active very active

How many fruits and vegetables do you eat daily? _____ Fruits _____ Vegetables

Do you exercise at least 3 times per week for 30 minutes or more? Yes No

How many 8-ounce glasses of water do you drink daily? _____

Are you currently taking any vitamin supplements? Please list below.

# Per Day	Vitamin/Supplement and Brand (List all that you are currently taking)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or other medical/legal services engaged on my behalf.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- Parent or Guardian: I authorize the staff to administer treatment as deemed necessary for my _____

Indicate Relationship

Signature _____ Date _____ / _____ / _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Duluth MultiCare originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Duluth MultiCare is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Duluth MultiCare reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Duluth MultiCare change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information: _____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature (authorized representative signing for the patient)

Date

FOR OFFICE USE ONLY

Consent received by _____ on _____

Consent refused by patient, and treatment refused as permitted.

Consent added to the patient's medical record on _____

TPO CONSENT