WHAT'S NEW

1 ABOUT YOU

Today's Date: _____ /_____ /_____

Patient Name: _____
LAST FIRST MI

Mailing Address: _____
(k UNCHANGED)

_____
CITY STATE ZIP

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

E-mail Address: _____

Employer: _____
(k UNCHANGED)

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Marital Status: _____
(k UNCHANGED)

Spouse's Name: _____

2 INSURANCE INFO

Has any of your Insurance Information changed? k Yes k No
If your insurance info has **not** changed, please continue to block 3.

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: _____

____ Initials I hereby authorize assignment of my insurance rights and 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 this office).

Pleaser provide any **new** Primary/Secondary Insurance cards with this form.

3 MEDICAL INFO

What Medications are you taking? (please include over-the-counter drugs) _____

_____

Please list any **new** physical condition, injury or problems, include dates when possible: _____

_____

_____

In event of an emergency, whom should we contact? _____

Relation: _____ Phone: (_____) _____ Cell: (_____) _____

Who is your medical doctor? _____ Phone: (_____) _____

Has our office/staff met or surpassed your expectation of treatment? k Yes k No k Somewhat

Comments: (if any) _____

_____

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 further changes to the information I have provided.

Signature _____ Date: _____ /_____ /_____

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

Patient Health Questionnaire - PHQ

Patient Name: _____ Date _____

1. Describe your symptoms: _____

_____

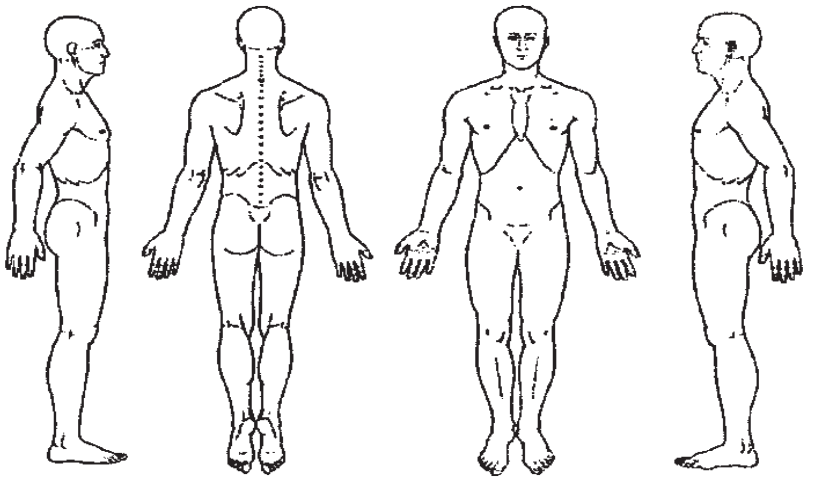
_____

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)



None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

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>:

a. Indicate the average intensity of your symptoms

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 <u>past 4 weeks</u> 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 Other Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms

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 recieved 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 Tradesperson ⑥ FT Student

_____

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

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

Patient Signature _____ **Date** _____

BACK INDEX

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesnít increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g.. on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score

NECK INDEX

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.

① The pain is mild and does not vary much.

② The pain comes and goes and is moderate.

③ The pain is moderate and does not vary much

④ The pain comes and goes and is very severe.

⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I have no trouble sleeping.

① My sleep is slightly disturbed (less than 1 hour sleepless).

② My sleep is mildly disturbed (1-2 hours sleepless).

③ My sleep is moderately disturbed (2-3 hours sleepless).

④ My sleep is greatly disturbed (3-5 hours sleepless).

⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.

① I can read as much as I want with slight neck pain.

② I can read as much as I want with moderate neck pain.

③ I cannot read as much as I want because of moderate neck pain.

④ I can hardly read at all because of severe neck pain.

⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.

① I can concentrate fully when I want with slight difficulty.

② I have a fair degree of difficulty concentrating when I want.

③ I have a lot of difficulty concentrating when I want.

④ I have a great deal of difficulty concentrating when I want .

⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.

① I can only do my usual work but no more.

② I can only do most of my usual work but no more.

③ I cannot do my usual work.

④ I can hardly do any work at all.

⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.

① I can look after myself normally but it causes extra pain.

② It is painful to look after myself and I am slow and careful.

③ I need some help but I manage most of my personal care.

④ I need help every day in most aspects of self care.

⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.

① I can lift heavy weights but it causes extra pain.

② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).

③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.

④ I can only lift very light weights.

⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.

① I can drive my car as long as I want with slight neck pain.

② I can drive my car as long as I want with moderate neck pain.

③ I cannot drive my car as long as I want because of moderate neck pain.

④ I can hardly drive at all because of severe neck pain.

⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.

① I am able to engage in all my usual recreation activities with some neck pain.

② I am able to engage in most but not all my usual recreation activities because of neck pain.

③ I am only able to engage in a few of my usual recreation activities because of neck pain.

④ I can hardly do any recreation activities because of neck pain.

⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.

① I have slight headaches which come infrequently.

② I have moderate headaches which come infrequently.

③ I have moderate headaches which come frequently.

④ I have severe headaches which come frequently.

⑤ I have headaches almost all the time.

Neck Index Score

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?

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

k Consent received by _____ on _____

k Consent refused by patient, and treatment refused as permitted.

k Consent added to the patient's medical record on _____

TPO CONSENT