WELCOME

HELP YOUR BODY HEAL ITSELF WITH CHIRPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name: _____ Date: _____ SS# _____
First MI Last

Address _____ City _____ State _____ Zip _____

Sex: ❑Female ❑ Male

Birth date _____ Cell phone # _____ Work phone # _____

Email Address: _____

Are you: ❑Minor ❑ Married ❑Divorced ❑Widowed ❑Single ❑Separated

Your employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work phone # _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

Patient Health Questionnaire – PHQ

ACN Group

ACN Use only rev. 9/11/2002

Patient Name _____ Date _____

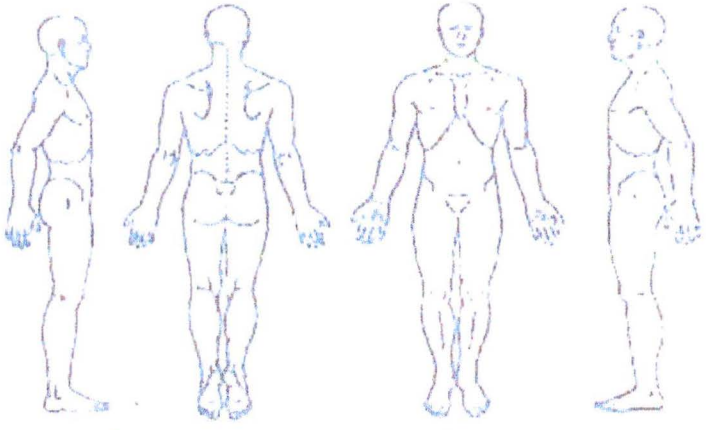
1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience 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 (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>:

   None Unbearable

   a. Indicate the average intensity of your symptoms (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

   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 <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 test have you had for your symptoms.
   and when were they performed?
   (1) X-rays 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) 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 (3) Self-employed (5) Off work
    (2) Part-time (4) Unemployed (6) Other

Patient Signature _____ Date _____

Centerville Chiropractic
WILLIAM F. MARSTELLER, D.C.

145 SOUTH MAIN STREET
CENTERVILLE, OHIO 45458
937-433-4800 • Fax 433-2618

To Our Patients:

Notice of Privacy Practices effective: April 14, 2003

Centerville Chiropractic understands that your personal information needs to be kept private. Protecting your personal information is important. We follow strict federal and state laws that require us to keep your personal information confidential.

Centerville Chiropractic is required by law to:

- Maintain the privacy of your personal information
- Provide this notice that describes the ways we may use and share your personal information
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain.
Current notices will be posted in the Centerville Chiropractic office. Please take the time to read this notice and feel free to request a copy for your own records.

Payment: We keep records that include payment information, and documentation of the services provided to you. Your information may be used to obtain payment for your services from Medicaid, Medicare, insurance or other sources. With so many insurance companies and insurance plans on the market, it is impossible for us to be familiar with all of them. Therefore, it is your responsibility to know your insurance plan. **If a referral is required, you must secure one from your family physician or the insurance company whichever applies, prior to your appointment.**
If you do not cancel your appointment within 24 hours, you will be **charged 50% of the service charge**.

I understand that I am financially responsible for services rendered from Dr. William Marsteller. If my insurance company does not pay for my services I understand that I must pay for the services rendered to me.

I further understand that I am responsible for any/all deductible and/or co-payment amounts that my insurance company applies to my account.

Patient: _____ Date: _____

Responsible Person: _____ Date: _____
Signature

Witness: _____ Date: _____
Signature

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: _ / / _____**Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis *Example: Heart Disease* **(Write in below)**	Father	Mother X	Sibling: ( )	Offspring: ( )

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication Name	Dosage and Frequency (i.e. 5mg once a day,etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date

Height: _____ Weight: _____ Blood Pressure:_____

Patient Signature:_____ **Date:**_____