BEAR CREEK CHIROPRACTIC CENTER

Dr. Guy D. Backstrom, D.C.
8105 166th AVE NE #101
Redmond, WA 98052

DATE: _____

PATIENT INFORMATION: (CONFIDENTIAL)

NAME: _____DATE OF BIRTH: _____

ADDRESS:_____CITY: _____ST:___ZIP:_____

CELL PHONE #: _____HOME #:_____

EMAIL ADDRESS: _____

MARITAL STATUS: _____SOCIAL SECURITY #: _____

OCCUPATION: _____Employer: _____

How did you hear about us? _____

RESPONSIBLE PARTY: (CHECK ONE)

☐ INSURANCE COMPANY (PLEASE GIVE US CARD TO COPY) _____

NAME OF INSURED IF OTHER THAN SELF: _____

RELATIONSHIP TO PATIENT: _____DATE OF BIRTH: _____

☐ CASH OR CHECK

☐ AUTO ACCIDENT OR WORK INJURY – DATE OF INJURY _____

_____

IN CASE OF EMERGENCY:

NAME: _____RELATIONSHIP TO PATIENT: _____

PHONE #:_____

WHO MAY WE THANK FOR REFERRRING YOU TO THIS OFFICE? _____

ACN Group, Inc. Use Only rev 3/27/2003

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

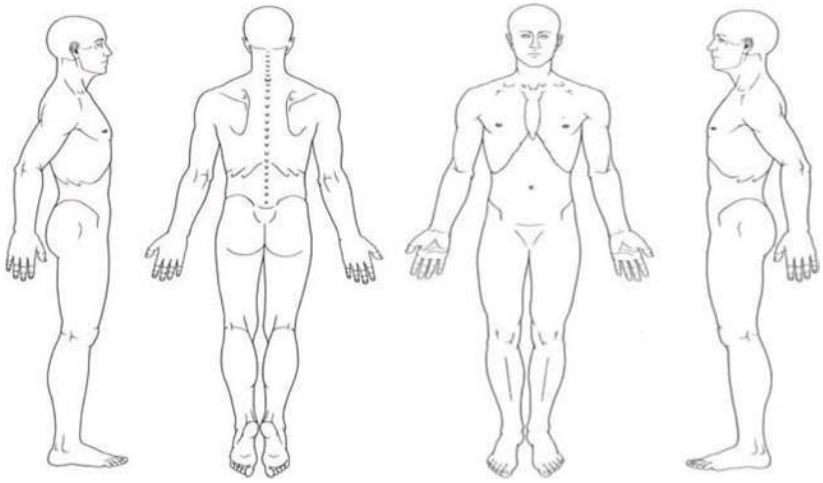
a. When did your symptoms start? _____

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



None *Unbearable*

☐ ⓪ ☐ ① ☐ ② ☐ ③ ☐ ④ ☐ ⑤ ☐ ⑥ ☐ ⑦ ☐ ⑧ ☐ ⑨ ☐ ⑩

3. What describes the nature of your symptoms?

☐ ①Sharp ☐ ④Shooting
☐ ② Dull ache ☐ ⑤ Burning
☐ ③Numb ☐ ⑥Tingling

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

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

☐ ①Not at all ☐ ②A little bit ☐ ③Moderately ☐ ④Quite a bit ☐ ⑤Extremely

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...

☐ ①Excellent ☐ ②Very Good ☐ ③Good ☐ ④Fair ☐ ⑤Poor

8. Who have you seen for your symptoms?

☐ ① No One ☐ ③ Medical Doctor ☐ ⑤ Other
☐ ②Chiropractor ☐ 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?

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

9. Have you had similar symptoms in the past?

☐ ①Yes ☐ ②No

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

☐ ① This Office ② ☐ ③ Medical Doctor ☐ ⑤Other
☐ Chiropractor ☐ ④ Physical Therapist

10. What is your occupation?

☐ ① Professional/Executive ② ☐ ④ Laborer ☐ ⑦Retired ⑧
☐ White Collar/Secretarial ☐ ⑤ Homemaker 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 ☐ ⑤Off work
☐ ②Part-time ☐ ④ Unemployed ☐ ⑥Other

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height ☐☐☐ (*Feet* *Inches*) Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
☐	☐	Headaches
☐	☐	NeckPain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Hand Pain
☐	☐	Wrist Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue Muscular
☐	☐	Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

Past	Present	
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement Pregnancy

Other Health Problems/Issues

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANK WHERE APPROPRIATE.

1. Have you been treated for any other health conditions within the last year? _____

   _____

2. Please list any previous operations/surgeries. _____

   _____

3. Please list any previous trauma or accidents. _____

   _____

4. Family Medical History:

   Mother: _____

   Father: _____

   Siblings: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary forms and billings to collect from my insurance carrier as a courtesy. Any amount paid to this office will be credited to my account; however, I fully understand that I am personally responsible for payment. If payment is made directly to me by my insurance, I agree to make equal and immediate payment to this office. I also understand that if I suspend or terminate my treatment, any fees for professional services may become due and payable immediately. A $5 minimum or 1% per month finance charge may be added to any account over 90 days.

I hereby authorize this office to treat my condition as deemed appropriate through use of spinal adjustments and other chiropractic methods. I understand that any amount paid for x-rays is for examination and that the negative remain the property of this office, although I may request them for review.

In the event of difficulty with my insurance company, I authorize this office to initiate a complaint to the insurance commissioner on my behalf.

Patient's Signature: _____ Date: _____

PLEASE SIGN AND RETURN TO THE OFFICE MANAGER

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to apy for all costs and expenses, including reasonable attorney fees. I hereto authorize the doctor to release information necessary to secure payment of benefits.

Patient's Signature: _____ Date: _____

If this appointment is for a minor, parent or guardian signature authorizing treatment:

Signature: _____Date: _____

Witness' signature _____

Acknowledgement of Receipt of Statement of Privacy Notice

Dr. Guy D. Backstrom, D.C.
Bear Creek Chiropractic
8105 166th AVE NE #101
Redmond, WA 98052

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Guy D. Backstrom, D.C. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Guy D. Backstrom, D.C. reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after revision become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE ONLY	☐ YES	☐ NO
OTHER (SPECIFY)	☐ YES	☐ NO

_____ _____

Name of Patient **Signature of Patient**

_____

Date

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

Provided prior to treatment? __ YES __ NO

Date Provided: _____

Reason for Denial:

____ Needed more time to Review the Statement of Privacy Practices
____ Wanted to consult with another person, before signing.
____ Unable to Sign
____ Reason not Given
____ Other (explain) _____