

**CONFIDENTIAL PATIENT INFORMATION SHEET**

Patient \_\_\_\_\_ Home Telephone \_\_\_\_\_  
first middle last

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Cell Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Married\_\_ Single\_\_ Widow(er)\_\_ Divorced\_\_ Number of Children\_\_

Occupation/Profession \_\_\_\_\_ Business Phone \_\_\_\_\_

Patient

Spouse

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

Referred By? \_\_\_\_\_

Is this related to: work\_\_ auto\_\_ other\_\_

Do you have health and/or accident insurance? Yes\_\_ No\_\_

Health Plan \_\_\_\_\_ Patient ID# \_\_\_\_\_

Subscribers Name \_\_\_\_\_

Subscribers ID# \_\_\_\_\_

Subscribers Group# \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

Subscribers Date of Birth \_\_\_\_\_

**Insurance or financial arrangements can be made at this time.**

Copays are due at time of treatment.

Back to Wellness Clinic, 1706 Lor Ray Drive North Mankato, MN 56003  
Dehen Chiropractic, Ltd.: Voice (507)388-7744 Email [dehenchiro@juno.com](mailto:dehenchiro@juno.com)  
SchugelFamily Chiropractic PA: Voice (507)385-1015 Email [mschugel@hickorytech.net](mailto:mschugel@hickorytech.net)

# Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

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

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

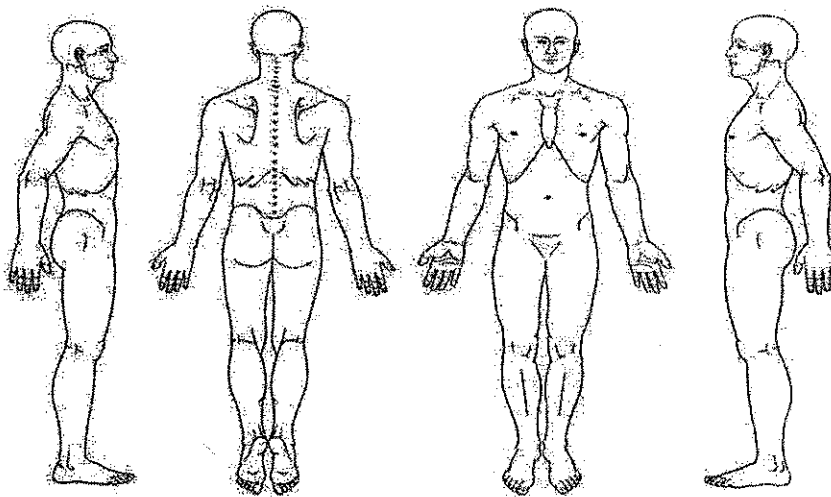
\_\_\_\_\_  
\_\_\_\_\_

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 Unbearable 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 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 and when were they performed?

- 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
- ① This Office
- ② Other Chiropractor
- 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
- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# Patient Health Questionnaire - page 2

ChiroCare of Minnesota, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What type of regular exercise do you perform?      ① None      ② Light      ③ Moderate      ④ Strenuous

What is your height and weight?      Height 

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      Weight 

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 lbs.  
Feet      Inches

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.

- |  |   |  |
|--|---|--|
| <p><b>Past Present</b></p> <p><input type="radio"/> <input type="radio"/> Headaches</p> <p><input type="radio"/> <input type="radio"/> Neck Pain</p> <p><input type="radio"/> <input type="radio"/> Upper Back Pain</p> <p><input type="radio"/> <input type="radio"/> Mid Back Pain</p> <p><input type="radio"/> <input type="radio"/> Low Back Pain</p> <p><input type="radio"/> <input type="radio"/> Shoulder Pain</p> <p><input type="radio"/> <input type="radio"/> Elbow/Upper Arm Pain</p> <p><input type="radio"/> <input type="radio"/> Wrist Pain</p> <p><input type="radio"/> <input type="radio"/> Hand Pain</p> <p><input type="radio"/> <input type="radio"/> Hip/Upper Leg Pain</p> <p><input type="radio"/> <input type="radio"/> Knee/Lower Leg Pain</p> <p><input type="radio"/> <input type="radio"/> Ankle/Foot Pain</p> <p><input type="radio"/> <input type="radio"/> Jaw Pain</p> <p><input type="radio"/> <input type="radio"/> Joint Swelling/Stiffness</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p> <p><input type="radio"/> <input type="radio"/> Rheumatoid Arthritis</p> <p><input type="radio"/> <input type="radio"/> General Fatigue</p> <p><input type="radio"/> <input type="radio"/> Muscular Incoordination</p> <p><input type="radio"/> <input type="radio"/> Visual Disturbances</p> <p><input type="radio"/> <input type="radio"/> Dizziness</p> | <p><b>Past Present</b></p> <p><input type="radio"/> <input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> <input type="radio"/> Heart Attack</p> <p><input type="radio"/> <input type="radio"/> Chest Pains</p> <p><input type="radio"/> <input type="radio"/> Stroke</p> <p><input type="radio"/> <input type="radio"/> Angina</p> <p><input type="radio"/> <input type="radio"/> Kidney Stones</p> <p><input type="radio"/> <input type="radio"/> Kidney Disorders</p> <p><input type="radio"/> <input type="radio"/> Bladder Infection</p> <p><input type="radio"/> <input type="radio"/> Painful Urination</p> <p><input type="radio"/> <input type="radio"/> Loss of Bladder Control</p> <p><input type="radio"/> <input type="radio"/> Prostate Problems</p> <p><input type="radio"/> <input type="radio"/> Abnormal Weight Gain/Loss</p> <p><input type="radio"/> <input type="radio"/> Loss of Appetite</p> <p><input type="radio"/> <input type="radio"/> Abdominal Pain</p> <p><input type="radio"/> <input type="radio"/> Ulcer</p> <p><input type="radio"/> <input type="radio"/> Hepatitis</p> <p><input type="radio"/> <input type="radio"/> Liver/Gall Bladder Disorder</p> <p><input type="radio"/> <input type="radio"/> Cancer</p> <p><input type="radio"/> <input type="radio"/> Tumor</p> <p><input type="radio"/> <input type="radio"/> Asthma</p> <p><input type="radio"/> <input type="radio"/> Chronic Sinusitis</p> | <p><b>Past Present</b></p> <p><input type="radio"/> <input type="radio"/> Diabetes</p> <p><input type="radio"/> <input type="radio"/> Excessive Thirst</p> <p><input type="radio"/> <input type="radio"/> Frequent Urination</p> <p><input type="radio"/> <input type="radio"/> Smoking/Use Tobacco Products</p> <p><input type="radio"/> <input type="radio"/> Drug/Alcohol Dependence</p> <p><input type="radio"/> <input type="radio"/> Allergies</p> <p><input type="radio"/> <input type="radio"/> Depression</p> <p><input type="radio"/> <input type="radio"/> Systemic Lupus</p> <p><input type="radio"/> <input type="radio"/> Epilepsy</p> <p><input type="radio"/> <input type="radio"/> Dermatitis/Eczema/Rash</p> <p><input type="radio"/> <input type="radio"/> HIV/AIDS</p> <p><b>Females Only</b></p> <p><input type="radio"/> <input type="radio"/> Birth Control Pills</p> <p><input type="radio"/> <input type="radio"/> Hormonal Replacement</p> <p><input type="radio"/> <input type="radio"/> Pregnancy</p> <p><input type="radio"/> <input type="radio"/></p> <p><b>Other Health Problems/Issues</b></p> <p><input type="radio"/> <input type="radio"/></p> <p><input type="radio"/> <input type="radio"/></p> <p><input type="radio"/> <input type="radio"/></p> |
|--|---|--|

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 \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns:  +  +

TOTAL:

<p>10. If you checked off <i>any</i> problems, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at [ris8@columbia.edu](mailto:ris8@columbia.edu). Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

## Back to Wellness Clinic Informed Consent

**To the patient:** Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign, if there is anything that is unclear.

### **The nature of the chiropractic adjustment.**

The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your own knuckles. You may also feel a sense of movement.

### **Examination and Treatment**

In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the examination, and treatment, you are consenting to the following procedures:

- |   |  |
|---|--|
| <input type="checkbox"/> spinal manipulative therapy  | <input type="checkbox"/> palpation                               |
| <input type="checkbox"/> vital signs                  | <input type="checkbox"/> orthopedic testing                      |
| <input type="checkbox"/> range of motion testing      | <input type="checkbox"/> basic neurological exam                 |
| <input type="checkbox"/> muscle strength testing      | <input type="checkbox"/> ultrasound                              |
| <input type="checkbox"/> radiographic studies         | <input type="checkbox"/> Rehabilitation/Core strengthening       |
| <input type="checkbox"/> nutritional therapy          | <input type="checkbox"/> mechanical traction/flexion distraction |
| <input type="checkbox"/> Other (please explain) _____ |  |

### **The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

### **The probability of those risks occurring.**

**Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.**

**Soreness:** It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.

**Fracture:** Fractures caused from spinal manipulation are extremely rare, so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation are utilized for this type of patient.

**TIA/Stroke:** According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks. Studies have indicated, "Prescription non-steroidal anti-inflammatory drugs (like aspirin) carry a significantly greater risk than manipulation." (*Fries, J.F. Assessing and Understanding Patient Risk. Scand, J. Rheumatol 1992; Supp 92:21.*)

**Ruptured/Herniated Disc:** There have been some reports of herniated or ruptured discs caused by spinal manipulation. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

**Other complications** include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

**The availability and nature of other treatment options.**

Other treatment options for your condition may include:

- Self-administered, over-the-counter medications
- Medical care and prescription drugs, such as anti-inflammatories, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are also risks and benefits with each of those options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated.**

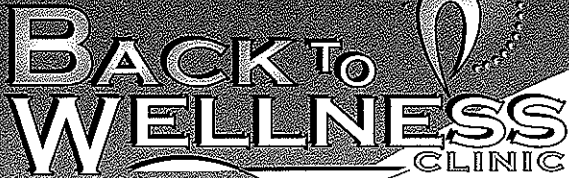
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.  
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Dehen/Schugel and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



- DEHEN CHIROPRACTIC, LTD
- SCHUGEL FAMILY CHIROPRACTIC, PA
- FEMRITE FAMILY NUTRITION, INC.

### ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits to **BACK TO WELLNESS CLINIC** for the services described.

I give my permission to the physicians to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and/or my minor children.

I realize that I am responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles and noncovered services, i.e. laser therapy, orthotics, kinesiotaping, nutritional supplements, Biofreeze, etc. *Copays and cash plans are due at the time of service.*

If I allow my account to become delinquent and it is referred to a collection agency, I am solely responsible for any outstanding balances and all reasonable collection costs and attorneys fees.

Special arrangements can be made, but must be mutually agreed to *in advance*. Please contact the staff at any time if you have any difficulties. We will do everything possible to find a way to provide the health care services you need.

My signature indicates my authorization of this activity.

Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

### HIPAA DISCLOSURE

I have been presented with the HIPAA disclosure information and am aware of my rights and obligations.

My signature indicates my authorization of this activity.

Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

# Acknowledgement of Financial Responsibility

## Non-Covered Services Annual Disclosure Form



As your Doctor of Chiropractic, I want to provide you with the best possible care. There are services that I feel are in your best interest for the treatment of your condition and maintenance of good health that may not be covered by your health insurance coverage. You will be expected to pay for those services in full. Let me reassure you that I will only provide care that I feel is necessary.

Covered services traditionally include:

- Treatment that has the potential to significantly improve a clinical condition.
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists.

Services not covered include:

- ✓ Some Diagnostic Services
- ✓ Some Therapeutic Services
- ✓ Some Durable Medical Products (including braces, ice packs, etc.)
- ✓ Maintenance Care aka Elective Care.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## Non-Covered Services Treatment Plan Disclosure Form

I, \_\_\_\_\_ have chosen to receive the following care that is not covered  
(*patient's name*)

by my health plan and I agree to pay the full charge(s) for the following service(s):

# of Visits and date of expected last visit	Description of Services	Approximate Cost

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Provider Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Form expires on the date of the last visit as noted in the treatment plan section or one year from signature date in the annual section, which ever comes first.