PATIENT HEALTH QUESTIONNAIRE

Name_____ Date_____

Please fill in the blanks and check all items where appropriate. In the space below, please describe the present complaint(s) which brought you to our office. This information will assist us in obtaining an early understanding of your health.

Present complaint:_____

Causation:

What was/is the cause of this complaint?

[ ] Auto accident [ ] Work injury [ ] Accident [ ] Trauma
[ ] Illness [ ] Congenital (born with it) [ ] Unknown

When did this complaint begin? Date, if known: _____

[ ] few days ago [ ] last week [ ] couple of weeks ago
[ ] several weeks ago [ ] about a month ago [ ] several months ago
[ ] more than one year ago [ ] several years ago
[ ] childhood

Have you had this same complaint before this onset? [ ] Yes [ ] No
If yes, how many times before have you had this complaint? _____

Is your current complaint: [ ] improving [ ] worsening
[ ] staying the same [ ] intermittent

Onset of condition: [ ] gradual [ ] sudden [ ] unknown

Please list any past hospitalizations, broken bones, accident, and/or injuries:

_____
_____
_____

Severity/ Sensations/ Pain Types:

Is your current complaint causing: [ ] Inflexibility [ ] Restricted movement [ ] Stiffness

Is your current complaint causing any of the following sensations:
[ ] Crawling [ ] Dead [ ] Numb [ ] Pins and Needles [ ] Prickly [ ] Tingling

Describe your pain type:
[ ] Achy [ ] Burning [ ] Dull [ ] Excruciating [ ] Numb ache [ ] Pounding
[ ] Pulsating [ ] Sharp [ ] Shooting [ ] Stabbing [ ] Stinging [ ] Throbbing
[ ] Sore [ ] Stiffness [ ] Tight [ ] Electric Shock

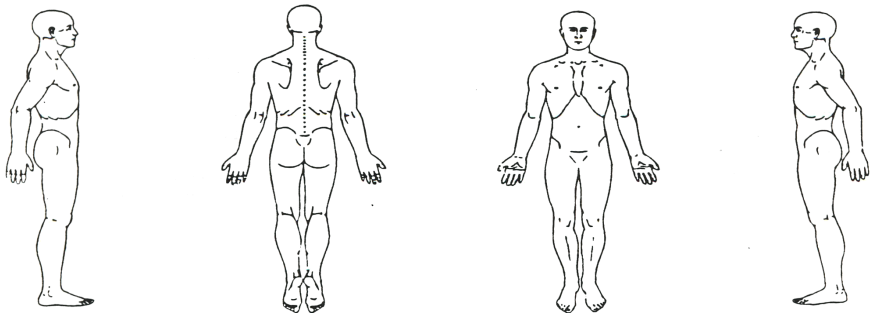
Check the activities that **AGGRAVATE** your current complaint:
[ ] Coughing [ ] Sneezing [ ] Straining at BMs [ ] Looking down [ ] Looking up [ ] Reclining
[ ] Repetitious movements [ ] Sleeping [ ] Turning head to left [ ] Turning head to right
[ ] Emotional upsets [ ] Stress [ ] Getting out of bed [ ] Lifting [ ] Pulling [ ] Pushing
[ ] Sitting [ ] Standing [ ] Stooping [ ] Bending [ ] Exercise [ ] Shoveling [ ] Raking
[ ] Other: _____

Check the activities that **RELIEVE** your current complaint:
[ ] Adjustments [ ] Advil [ ] Aspirin [ ] Tylenol [ ] Pain Pills [ ] Exercising [ ] Reclining
[ ] Resting [ ] Sitting [ ] Sleeping [ ] Cold [ ] Heat [ ] Rubbing Heat Liniment
[ ] Nothing [ ] Hot showers [ ] Rubbing Mineral ice [ ] Mechanical Traction
[ ] Stretching [ ] Tub soaking [ ] Other: _____

How often are you experiencing your current complaint?
[ ] Constant [ ] Frequent [ ] Intermittent [ ] Occasional

Please **rate** your **pain when it is at its WORST**:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Please outline on the diagram the area of your discomfort. A=Aches, B=Burning, P= Pins & Needles, S=Stabbing, O=Other



Review of Systems:
If you have an issue in a section below, check the box. If you have no problems relating to that question, check the "No Problems" box.

Do you have any ill feelings?
[ ] Decreased activity level [ ] Fever [ ] Chills [ ] Fatigue [ ] Night sweats [ ] Loss of Appetite
[ ] Weight loss [ ] Weight gain [ ] Loss of energy [ ] Uncontrolled sweating
[ ] NO PROBLEMS

Do you have any mental problems?
[ ] Irritability [ ] Depression [ ] Disturbed sleep [ ] Suicidal thoughts [ ] Anxiety
[ ] Nervousness [ ] NO PROBLEMS

Do you have trouble urinating?
[ ] Frequent Urination [ ] Urgency [ ] Trouble stopping or starting [ ] Erectile Dysfunction
[ ] Nocturia (nighttime urination) [ ] Burning with urination [ ] Losing control/incontinence
[ ] Bowel Dysfunction [ ] Sexual Dysfunction [ ] Hesitancy [ ] NO PROBLEMS

Do you have trouble with your vision?
[ ] Blurred vision [ ] Double vision [ ] Vision loss [ ] Eye pain [ ] Glasses/contacts
[ ] NO PROBLEMS

Do you have any symptoms of heart trouble?
[ ] Chest pain [ ] Palpitations [ ] Fainting [ ] Shortness of Breath [ ] Ankle Swelling
[ ] NO PROBLEMS

Do you have any breathing problems?
[ ] Coughing [ ] Wheezing [ ] Shortness of Breath [ ] NO PROBLEMS

Do you have stomach problems?
[ ] Nausea [ ] Vomiting [ ] Diarrhea [ ] Constipation [ ] Loss of Bowel Control
[ ] NO PROBLEMS

Do you have muscle or joint problems?
[ ] Joint pain [ ] Joint swelling [ ] Muscle weakness [ ] NO PROBLEMS

Do you have any skin problems?
[ ] Rash [ ] Itching [ ] Dryness [ ] Lesions [ ] Open wound/infection [ ] Hair/nail changes
[ ] NO PROBLEMS

Do you have any immunity problems?
[ ] Enlarged lymph nodes [ ] Hives [ ] Hay Fever [ ] Persistent infections [ ] NO PROBLEMS

Do you have any endocrine problems?
[ ] Diabetes [ ] Thyroid disorder [ ] NO PROBLEMS

Do you have any neurological problems?
[ ] Seizures [ ] Abnormal sensory feelings in extremity [ ] Loss of memory [ ] NO PROBLEMS

Do you have bruising or bleeding problems?
[ ] History of Anemia [ ] Abnormal bleeding [ ] Bruising [ ] Heat intolerance [ ] Cold intolerance
[ ] NO PROBLEMS

Past Medical History:

Check all past and present medical health problems:
[ ] Diabetes [ ] Lung Disease [ ] Stomach problems [ ] Ulcer disease
[ ] Kidney disease [ ] Mitral valve prolapse [ ] High cholesterol [ ] Heart problems
[ ] Liver problems [ ] Asthma
[ ] Bleed easily [ ] Arthritis [ ] OTHERS: _____
[ ] None, I am in good health

List Past Surgeries:
_____

Social History:

Are you working? [ ] Yes [ ] No

What best describes your work?
[ ] Retired [ ] Not Employed
[ ] Sedentary duty (occasional lifting/carrying small items-10lbs max- walking and standing occasionally)
[ ] Light duty (Frequent lifting-20lbs max- and carrying objects-10lbs max- significant waling/standing with sitting, pushing and pulling)
[ ] Medium duty (lifting-50lbs max- with frequent lifting/carrying objects-25lbs max)
[ ] Heavy duty (lifting 100lbs max- with frequent lifting/carrying objects 50lbs max)
[ ] Very heavy duty (lifting- heavier than 100lbs- frequent lifting/carrying- heavier than 50lbs)

Do you Drink Alcohol?
[ ] Never [ ] Occasionally [ ] Socially [ ] Frequently (more than 3days/week)

Have you ever had substance abuse treatment? [ ] Yes [ ] No
Have you ever used illegal drugs? [ ] Yes [ ] No

The federal government is requiring us to gather the following information as part of the Electronic Health Records system. Please answer the following questions:

Race (please circle):	White	Black or African American
	Asian	Native Hawaiian
	Other Pacific Islander	American Indian or Alaskan Native
	More than one	Undefined
	Refused to report/Unreported	

Ethnicity (please circle):	Hispanic or Latino	Not Hispanic/Latino
	Refused to report/ Unreported	Undefined

Preferred language: (Please circle)	English	Spanish	Hindi
	Vietnamese	Urdu	Other: _____
	Refused to report/ Unreported		

Please list any/all medications you are taking at this time and the precise dosage per day in mg:

1) _____

2) _____

3) _____

4) _____

5) _____

Continue on back or attach another page if needed…

Do you have any allergies to medications: YES_____ NO_____

Please explain what medications and the reactions:

_____

_____

_____

Smoking status (circle one):

Current, every day smoker Current, some days smoker

Former smoker Never smoked

Tobacco Use (circle one):

Current, every day smoker Current, some days smoker

Former smoker Never smoked

[ ] I am looking to quit smoking and would like information on how to do so

Current Height: _____ Current Weight: _____

TO BE FILLED OUT BY STAFF:

Blood pressure: _____ Pulse:_____

CONFIDENTIAL PATIENT INFORMATION SHEET

Name_____ Date_____

Spouse's Name_____ Children's Names_____

Address_____

City _____ State_____ Zip Code_____

Phone #'s: Cell _____Work _____Home_____

E-mail address: _____

Preferred Method of contact: _____

Drivers License #_____ Social Security #_____

Birth date _____ Marital Status: M S W D

Occupation_____ Employer_____

In case of emergency contact person and phone #_____

How did you hear about our office?_____

FOR **MINOR** PATIENTS, PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING THE PERSON(S) RESPONSIBLE FOR PAYMENT:
Name(s): _____ Phone: _____

Address: _____

Email: _____

Do you have health insurance? [ ] Yes [ ] No
If yes, please give all insurance cards to our staff to check benefits

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Have you had any previous Chiropractic care?

[ ] Yes [ ] No If yes, please answer the following:

Name of Dr. or Clinic: _____

Last known Date of Service: _____

iChiro Clinics
North Office- 4150 East Beltline Ave. Ste 3, Grand Rapids, MI 49525 616-447-9888
South Office- 6690 Crossings Dr Ste A, Grand Rapids, MI 49508 616-656-1830

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the iChiro Clinics procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the clinic staff who now or in the future treat me while employed by, working or associated with or serving as back-up, including those working at the clinic or office or any other office or clinic. I have had an opportunity to discuss with the clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all fees for professional services rendered to me will be immediately due and payable.

Name of Patient:_____

Signature of Patient:_____Date: _____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____Date: _____

Please list your current physicians. We believe a teamwork approach to your healthcare will give you the best results and would like to keep your physicians informed regarding your care.
I authorize iChiro/Peak Performance Chiropractic to send my medical information to the following physicians:

Dr. Name: **Clinic:** **Address:** **Phone:**

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Print Name: _____

Privacy Policies

I acknowledge that **iChiro/Peak Performance Chiropractic's** Notice of Privacy Practices has been provided to me. I understand I have a right to review it prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **iChiro/Peak Performance Chiropractic.** The Notice of Privacy Practices for **iChiro/Peak Performance Chiropractic** is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and **iChiro/Peak Performance Chiropractic's** duties with respect to my protected health information.

Ichiro/Peak Performance Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Open treatment areas video/audio documentation

Our office is concerned with providing the highest level of efficient service. We utilize an "open" treatment area for efficiency, and quality of care. Private areas are available for initial evaluations, and discussions of a private or personal nature. If you require a private area with a staff member, please advise us. If you are not comfortable with the "open" areas, some therapies may be available in a private area upon request.

We also utilize video/audio documentation of our "open" areas to ensure quality control, documentation, security, and for training purposes (no recordings in massage therapy rooms). All of this information is considered protected health information, and covered under our HIPAA privacy policies posted at the front desk.

I understand and consent to the "open" treatment areas, and the video/audio documentation procedures explained above.

Print Name_____

Signature_____

Date_____

If you do not wish to consent to these procedures, please notify our staff so we can refer you to another provider.

FRIENDLY REMINDER: DRINK LOTS OF WATER AFTER EVERY MASSAGE!

Massage Therapy at i-Chiro Clinics

Our Therapists - Our therapists work as a team. We feel that our patients benefit most from this teamwork approach, as they are able to take advantage of each therapist's individual style and expertise.

What to wear- Undress to your comfort level (always leaving underpants on) and lay face down on the massage table under a sheet and blanket. Patients unable to lie on their stomach may lie on their side. It is easiest for the therapist to palpate muscles and perform stretches without bulky shirts, belts, etc. All of our therapists are extremely professional, and only undrape the area being worked on. Therapists can work around clothing if a patient prefers to stay dressed.

Tips- We strive to keep cash prices low for massages and we also bill insurance for massage when applicable for your convenience. That being said, prices are not inflated to include gratuity for therapists. Tips are not required, but are accepted, and are always appreciated. Patients that do wish to tip their therapist may choose to follow a suggested guideline of 20% of the charge of service, or $5.00 to $20.00. Your therapist will receive your tip if you leave it in the massage room, or with the front desk staff. For your convenience, tips may be given in cash, personal check or on a credit card.

Cancellations- We cater to busy people, and do everything we can to offer flexible scheduling for our patients. Massage appointments require a 24 hour advance notice if you need to cancel your appointment. Our massage therapists work on an appointment basis, and a last minute cancellation creates a hole in their schedule. We often have a massage waiting list, and when a patient cancels at the last minute or no shows, patients on the waiting list miss out on a massage opportunity. Because of this, we do charge full price for any massage appointment cancelled without 24 hours notice.

Discounts- We offer a buy 10, get 12, money saving option for our cash paying customers. This requires payment for 10 massages up front, and gives you 2 additional massages for free. This if offered for both 25 minute and 55 minute massages, and can be used at your convenience.

Signing In- When you arrive to our office please sign in. After our patient coordinators have taken your information, you may have a seat in the lobby and your therapist will be with you shortly.

Upsets- We are here to serve you. Please speak with us about any upsetting manner. We see your comments as helping us to help you and others.

Payment- Payment is required at time of service. If you are using a voucher or coupon, it must be presented to our staff or you will be responsible for the full price of the massage.

Patient signature_____ Date_____

Massage **gift certificates** are available at the front desk, and make a wonderful gift.

FRIENDLY REMINDER: DRINK LOTS OF WATER AFTER EVERY MASSAGE!