Confidential Patient Information

Staker Chiropractic Center
3550 NW Cary Parkway, Suite 104 Cary NC, 27513
919-460-1515

Acct. # _____ Date_____

Name (First) _____ (Middle) _____ (Last) _____

Home Address_____ City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____ E-mail _____

Sex (M)___(F)___ Race/Ethnicity_____ Date of Birth ___/___/___ Age_____

Social Security Number____/____/____ Marital Status (Married) ____(Single)____ (Other)____

Occupation_____ Employer _____ Office Phone _____

Office Address_____ City _____ State____ Zip_____

Nearest friend or relative who may be called in case of an emergency_____

Relationship to Patient_____ Phone number_____

Name of Insurance Company_____Insured's Name_____

Insured's Date of Birth ___/___/___ Insured's Social Security Number ____/____/____

Insured's Employer_____Insured's Relationship to Patient_____

Previous Chiropractic Care (Yes)___ (No)___ Doctor's Name_____

Major Symptom_____

Who (or what source) referred you?_____

It is usual and customary to pay for services as rendered unless otherwise agreed.

I do hereby authorize Staker Chiropractic to furnish my Insurance Co. with a full report of physical examination, diagnosis, treatment prognosis, etc. of myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic service rendered me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me. This agreement is made solely for said doctor's additional protection and in consideration of him awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare the entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

I hereby authorize Dr. Todd Staker and whomever he may designate as his assistants to administer treatment, including x-rays and examination, necessary to treat at Staker Chiropractic Center.

Signature_____Minor's Name_____ Date___/___/___

Electronic Health Record Information

*Due to recent changes in the healthcare industry, we have been asked to obtain the following information on patients treated in our office.

Today's Date:_____ Name:_____ Date of Birth:_____

Contact Preference: __Home Phone_____
__Cell Phone _____
__Work Phone _____
__Email _____

General Information (Please select which applies):

Language: __English
__Spanish
__Indian
__Portuguese
__Chinese
__Finnish
__French
__German
__Other_____
__Decline to Answer

Race: __White
__Asian
__African American
__American Indian
__Alaska Native
__Hispanic
__Hawaiian/Pacific Islander
__Other_____
__Decline to Answer

Ethnicity:
__Hispanic/Latino
__Not Hispanic/Latino
__Decline to answer

Patient History:

Are you seeing anyone else for other problems or health conditions? __Yes __No

If yes, please list the problem(s), date problem(s) began, and the provider treating you for the condition(s):_____
_____
_____

Have you been diagnosed with Diabetes? __Yes __No

If yes, please select: __Type I __Type II

Do you smoke? __Never __Former Smoker __Some Day __Every Day

Please provide: Height_____ Weight_____ Blood Pressure_____

Do you have any allergies? __Food __Environmental __Medication __Other
If so, please list:_____
_____

STAKER chiropractic center

DR. TODD STAKER ❖ DR. BEN SCHEMMEL ❖ DR. TREVOR WILLIAMS
chiropractic physicians

3550 N.W. Cary Parkway, Suite 104 • Cary, NC 27513 • tel: 919.460.1515 • fax: 919.460.1979 • www.stakerchiropractic.com

Authorization for Releasing Information

At our office, we strive to give the best customer service possible. We understand that patients may have family or friends request medical and billing information on their behalf, and we want to provide our best for them as well. However, due to HIPAA law, we are unable to release information to anyone without the patient's written consent. If you wish to allow access to your medical and billing information to family or friends, please provide their information and sign below.

I authorize Staker Chiropractic Center to release my medical and/or billing information to the following individual(s):

Name_____ Relation to Patient_____

Name_____ Relation to Patient_____

Name_____ Relation to Patient_____

Name_____ Relation to Patient_____

Name_____ Relation to Patient_____

I understand that the information disclosed to any recipient listed above is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. I understand that I have the right to revoke this consent in writing at any time.

_____
Patient Signature

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

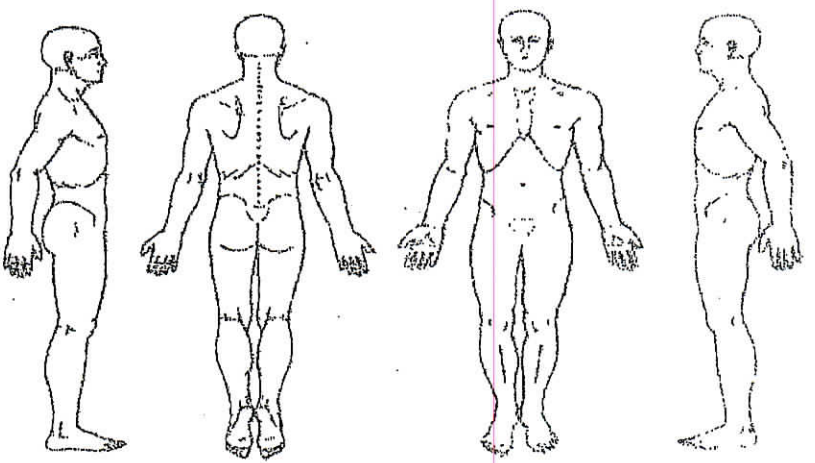
a. When did your symptoms start? _____

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



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 past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

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 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:* _____ 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
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

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

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

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

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 [ ][ ][ ] (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	
O	O	Headaches
O	O	Neck Pain
O	O	Upper Back Pain
O	O	Mid Back Pain
O	O	Low Back Pain
O	O	Shoulder Pain
O	O	Elbow/Upper Arm Pain
O	O	Wrist Pain
O	O	Hand Pain
O	O	Hip/Upper Leg Pain
O	O	Knee/Lower Leg Pain
O	O	Ankle/Foot Pain
O	O	Jaw Pain
O	O	Joint Swelling/Stiffness
O	O	Arthritis
O	O	Rheumatoid Arthritis
O	O	General Fatigue
O	O	Muscular Incoordination
O	O	Visual Disturbances
O	O	Dizziness

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

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

Females Only

O	O	Birth Control Pills
O	O	Hormonal Replacement
O	O	Pregnancy
O	O	

Other Health Problems/Issues

O	O
O	O
O	O

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

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O _____

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** _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

0----------1----------2----------3----------4

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0----------1----------2----------3----------4

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0----------1----------2----------3----------4

No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0----------1----------2----------3----------4

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0----------1----------2----------3----------4

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0----------1----------2----------3----------4

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0----------1----------2----------3----------4

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0----------1----------2----------3----------4

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0----------1----------2----------3----------4

No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0----------1----------2----------3----------4

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name: _____(Printed) ID#: _____ Group #: _____

Signature: _____ Date: _____ Total Score: _____