PATIENT REGISTRATION FORM

Patient Name: _____ **Date:** _____
First Middle Last

Date of Birth: _____ **Male ( ) Female ( ) City of Birth:** _____

Name of Spouse ( ) or Legal Guardian ( ): _____ **SSN:** _____

Phone #'s: Home: _____ Cell: _____ Work: _____

Mailing Address: _____

E-Mail Address: _____

Patient's Employer: _____ **Occupation:** _____

Employer's Address: _____

Employment Status: Full Time ( ) Part Time ( ) Retired ( ) Unemployed ( ) Student ( )
Patient Status: Single ( ) Married ( ) Minor ( ) Widow ( ) Other ( )

Referred By Whom: _____
Chiropractor ( ) MD ( ) Relative ( ) Friend ( ) Telephone Directory ( )

Insurance Information
Primary Insurance Company: _____
Address: _____
Policy #: _____ Group #: _____ Policy Holder: _____
Policy Holder's Relationship: _____ Policy Holder's DOB: _____

Secondary Insurance Company: _____
Address: _____
Policy #: _____ Group #: _____ Policy Holder: _____
Policy Holder's Relationship: _____ Policy Holder's DOB: _____

Check the following choices:
Preferred Language: English ( ) Other : _____

Race: White ( ) American Indian or Alaska Native ( ) Black or African-American ( ) Hispanic or Latino ( )
Multi-Racial ( ) Native Hawaiian or Pacific Islander ( ) Other Race ( )

List Current Medications None ( )

List Medication Allergies None ( ) Describe reaction to allergy mild mod severe

Smoking Status: Never smoker ( ) Former smoker ( ) Current every day smoker ( ) Current some day smoker ( )

Height: _____ inches **Weight:** _____ lbs. **Blood Pressure:** _____/_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY MEDICAL CHARGES NOT PAID BY MY INSURANCE COMPANY OR OTHER THIRD PARTY. PAYMENT IS EXPECTED AT TIME OF SERVICE.

Signed: _____ **Date:** _____

Patient Health Questionnaire

Patient Name _____ *Date* _____

1. When did your symptoms start: _____ *Describe your symptoms and how they began:*

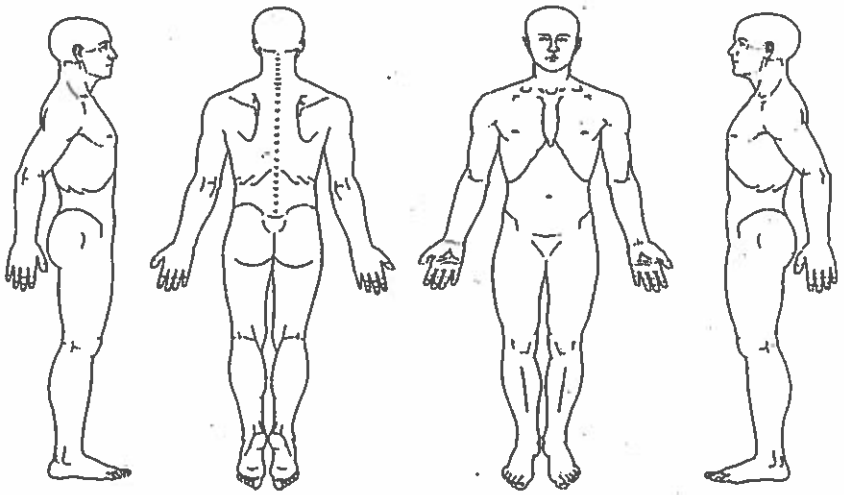
_____

_____

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. How bad are your symptoms at their:

	None										*Unbearable*
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

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:* _____

10. 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 Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. 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

12. What do you hope to get from your visit/treatment (select all that apply):

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Health Questionnaire - page 2

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 [ ][ ][ ] Weight [ ][ ][ ] 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.

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

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* _____

DENVER CHIROPRACTIC
107 South East Tenth Street
P.O. Box 908
Grand Rapids, MN 55744

PATIENT CONSENT FOR USE/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTH CARE OPERATIONS

I, the patient, hereby state that by signing this consent, I acknowledge and agree as follows:

1. Protected Health Information ("PHI") may be used and/or disclosed in order to carry out treament, payment or health care operations.
2. If you do not consent to the above use and/or disclosure, then this office will not treat you.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or health care operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.
4. This office reserves the right to change its privacy practices that are described in the above referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
5. You have a right to request that this office restrict how PHI is used and/or disclosed to carry out treatment, payment and/or health care operations.
6. This office is not required to agree to any restrictions that you have requested.
7. If this office agrees to a requested restriction, then the restriction is binding in the office.
8. You further understand that you have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that this office has already taken action in reliance on this consent.
9. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.
10. You will sign and date all consents requested to which you agree.

PATIENT CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of Gregory E. Denver, D.C., C.C.S.P. and it is the responsibility of the staff to carry out the instructions of such physician.

I have read and understand the foregoing notices, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (printed) **Signature of Individual**

_____ _____

Signature of Legal Representative **Relationship**

Date Signed_____/_____/_____ _____

Witness

DENVER CHIROPRACTIC P.A.
107 SE Tenth Street Ste. 1
Grand Rapids, MN 55744
218-326-0071

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by DENVER CHIROPRACTIC P.A. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date