Foundation Chiropractic Clinic

Tyler Emmert, D.C.

1830 BLANKENSHIP RD., SUITE 210

WEST LINN, OR 97068

503-557-1122

DATE _____

REFERRED BY _____

LAST NAME _____ FIRST NAME _____ MI_____

BIRTHDATE _____ AGE _____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE _____

WORK PHONE _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS __M __S__W__D__SEP CHILDREN:

(AUTO) If applicable:

Date of Injury:_____

Insurance:_____

Claim#:_____

Policy#: _____

Name/Age:_____

Name/Age:_____

Name/Age:_____

SPOUSE _____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

I HAVE READ, UNDERSTOOD AND ACCEPT THE OFFICE POLICY OF FOUNDATION CHIROPRACTIC CLINIC. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED AND/ OR NECESSARY IN ORDER TO PROCESS THIS CLAIM.

PATIENTS SIGNATURE (PARENT IF PATIENT IS A MINOR) _____

FOUNDATION CHIROPRACTIC CLINIC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

We consider the privacy of our patients to be a top priority. Following is a list of our policies and procedures that maintain your privacy. HIPAA (Health Insurance Portability and Accountability Act) requires that we inform you of how we may use the information in your patient file. We would be happy to answer any further questions you might have. If you would like a copy of this for your records, let us know.

YOUR HEALTH AND PERSONAL INFORMATION MAY BE USED WITH OR WITHOUT YOUR KNOWLEDGE:

- There may be a list of treatments and/or treatment dates on your mailed statements
- Information may be requested and sent to insurance companies in order to secure payment
- Other health care providers
- Among the staff in our office to provide you with the best chiropractic care possible
- Patient reminders, such as postcards or reminder phone calls
- We will disclose health information about you when required to do so by law
- Family, friends and caregivers who help provide home hygiene, medications, payment or transportation
- Anyone else you authorize in writing (revocable by you at any time)

YOUR RIGHTS REGARDING PERSONAL INFORMATION:

- Personal preferences – you may request that we do not discuss issues when other family members are present, or limit mail and phone contact. We will attempt to honor your reasonable requests
- You have the right to read, review or receive a copy of your chart information
- You may ask us to update or supplement your records if you feel they are inaccurate
- You may ask us how and where our office used your health information
- If you feel your rights have been violated please inform our office

Above all we want to earn your confidence. Thank you for allowing Foundation Chiropractic Clinic to provide for your chiropractic healthcare needs.

Sincerely,

Tyler Emmert, D.C.

PATIENT NAME: _____DATE:_____

PATIENT SIGNATURE_____

Foundation Chiropractic Clinic

Office Policy

We believe that every patient has the right to the very best professional care we can provide. In turn, we have established the following agreement between Doctor and patient and expect the cooperation of all parties per the following:

1. Your payment is due at the time of service. This includes payment for all co-pays and all cash paying patients unless a payment plan has been prearranged with our Clinic Administrator. This also includes payment for all supplements and supplies.

2. Your appointments are important to us and to you. In order to ensure that each patient is provided with quality treatment and time, we will see you in the order in which you are scheduled and not by reception room seniority. However, when a patient arrives late, others in the reception area will be seen in their scheduled order. If you have definite time constraints, please let our staff know at the time you scheduled your appointment, and we will do our best to accommodate you.

3. Missed/cancelled appointments: If you are not able to keep an appointment, please contact our office within 24 hours. **Missed or cancelled** appointment without **24 hours notice** will result in a **$25 charge**. We reserve appointment times with individual needs in mind and ask that notice is given in order to provide other patients with an opportunity to receive care. If you are on a treatment plan and cancel or miss an appointment, please contact our office by the following day in order to ensure that you receive the appropriate amount of care you need within that week.

4. Any new injuries or accidents will require that you fill out necessary paperwork and your visit may require x-rays and an examination. If we have not seen you in our office for six months or longer, a health update may be necessary.

5. We agree to bill your primary insurance for any treatment you receive in our office. However, please be advised that any charges your insurance does not cover will ultimately be your responsibility, as your contract is with your insurance company and our contract is with our patients. This includes any supplements or supplies you receive while under care in our office.

We appreciate your faith and confidence in selecting Foundation Chiropractic Clinic. We are here to serve you, your family, and this community's healthcare needs through the natural approach which chiropractic care provides.

I have read and agree to the above Office Policy. In the event of a dispute, I agree to pay for any fees incurred due to collection of a delinquent account, including collection services and/or attorneys' fees.

Patient Signature: _____ Date: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

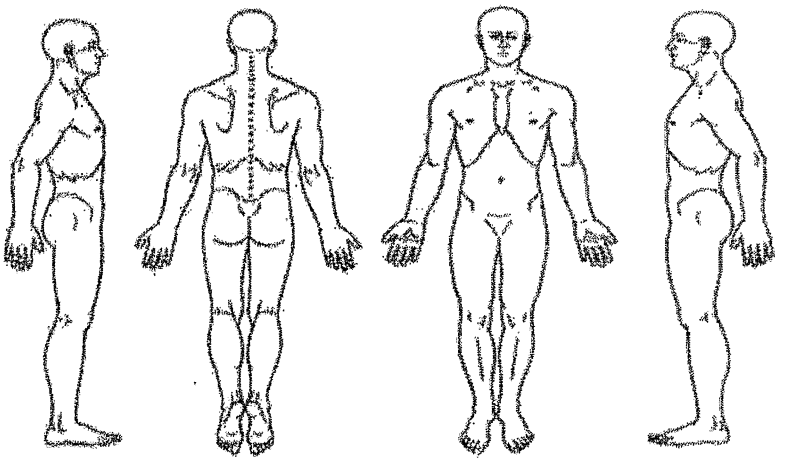
a. When did your symptoms start? _____

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



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

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

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*** _____