PERSONAL INFORMATION

Name: Age: Date of Birth: Gender: M F

Mailing Address: City: State: Zip:

SSN (for insurance purposes only): Email:

Home Phone: Cell Phone:

Emergency Contact: Relationship: Phone:

How were you referred to our clinic?

Primary Physician Phone: Date of last physical:

AUTHORIZATION FOR RELEASE OF INFORMATION (HIPPA)

I acknowledge that I have been informed about MT Team Chiropractic's Patient Privacy Policy (how my medical information may be used and disclosed and how I get access to that information). I have seen and read this policy, and have been offered a copy of it for my records.

I authorize MT Team Chiropractic to release the necessary information requested for insurance or legal purposes, or as requested by an authorized physician. I also authorize release of information from physicians or other health care facilities to MT Team Chiropractic as needed for Chiropractic records.

I recognize that the information disclosed may contain information that is protected by federal and state law, and I specifically consent to disclosure of such information.

Patient Name: Patient or Guarantor Signature: Date:

GUARANTOR/SPONSOR/LEGAL GUARDIAN INFORMATION

Guarantor Name: Date of Birth: SSN:

Mailing Address: City: State: Zip:

Relationship to Patient: Home Phone: Cell Phone:

*We will do our best to verify your insurance benefits. Based on that information, payment will be collected at the end of each appointment.
*Payment plans are available.
*If it becomes necessary to send your account to collection for non-payment, you will be responsible for all collection and legal fees incurred.
*I understand that I am financially responsible for payment in full for all charges incurred regardless of insurance coverage. Further, I understand that MT Team Chiropractic has no contracted agreement with any private insurance companies as those agreements are between the patient and his or her insurance company.
*I hereby authorize payment directly to MT Team Chiropractic from my insurance company, benefits otherwise payable to me, such payment not to exceed MT Team Chiropractic's regular charges for the services performed.
*If MT Team Chiropractic bills my insurance directly, I agree to pay any charges deemed "patient responsibility" within my individual insurance plan.
*If I am unable to pay my billed statement balance in full, a payment schedule will be implemented on the unpaid balance. All dates of service older than a year will be charged a monthly interest rate of 3%. I also acknowledge that monthly payments are required to keep accounts active.
*I understand that there may be some therapy equipment that will not be covered by my insurance company. I agree to pay for the items not covered at the time they are dispensed.

CANCELLATION / NO SHOW POLICY

If you are unable to keep your appointment, please call 3 hours in advance. Failure to do so will result in a $20 fee; this will not be covered by insurance. Your first 3 missed appointments will be charged the $20; after 3 missed appointments, you will be charged $50.

Patient Name: Patient Signature: Date:

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

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

*Patient Name*____________________ *Date*________________

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

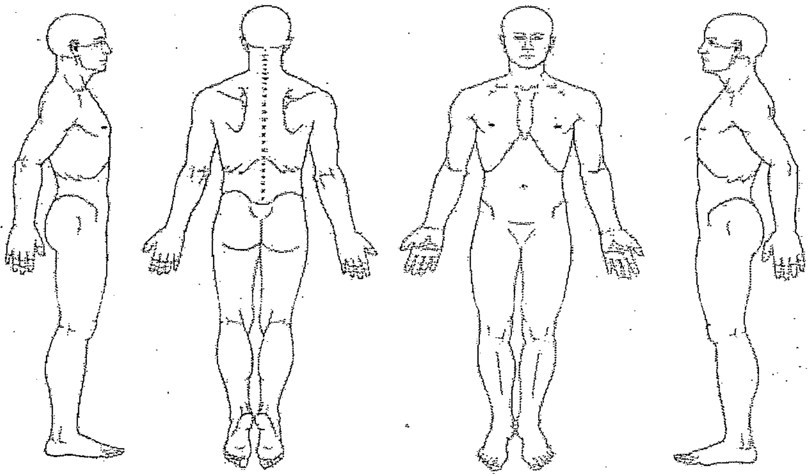
____

____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ 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? ☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

*a. When and what treatment?*________________

b. What tests have you had for your symptoms and when were they performed?
☐ Xrays *date:*______ ☐ CT Scan *date:*______
☐ MRI *date:*______ ☐ Other *date:*______

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? ☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

11. What is your occupation?
☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker ☐ FT Student ☐ Retired ☐ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status? ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other

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

- ☐ Reduce symptoms
- ☐ Resume/increase activity
- ☐ Explanation of condition/treatment
- ☐ Learn how to take care of this on my own
- ☐ How to prevent this from occurring again
- ☐

13. Have you previously received chiropractic care: Yes No

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

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

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

Do you consume alcohol: [ ] Daily [ ] Weekly [ ] Occasionally [ ] Never

Do you consume caffeine: [ ] Daily [ ] Weekly [ ] Occasionally [ ] Never

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

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

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ Auto Immune

Other: ______________________________

Please list any 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*** __________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, 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 known, is my best interest.

I have read, and 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 form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

To be completed by patient:

I hereby authorize the treatment of my minor son/daughter and have read the above consent information.

____
Print Patient's Name

____
Signature of Patient

____
(Parent/Guardian Signature)

____
Date Signed

To be completed by doctor or staff:

Montana Team Chiropractic

Doctor treating this patient: