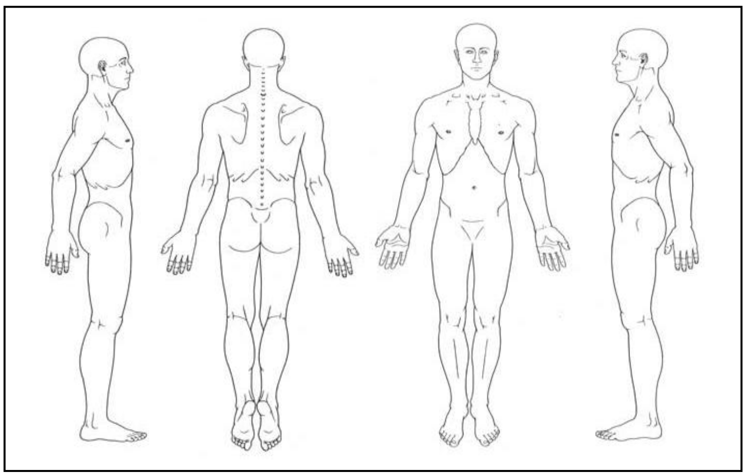
Mid-America Family Chiropractic, LLC
Mark Walters, D.C.

Patient Health Questionnaire
(Electronic Health Records)

Date: _______/_______/_______
First Name: ______________________________ Last Name: _______________________________ Middle Initial: _______
Home Address: _______________________________ City: ________________________ State: _______ Zip: __________
Date of Birth: _______/_______/_______ Social Security #: ___________________________ Gender: □ Male □ Female
Home Phone: ______________________ Cell Phone: ______________________ Work Phone: _____________________
E-Mail Address: ________________________@__________________ Marital Status: □ Single □ Married □ Other
Employer: ____ Occupation: ________________________________
Emergency Contact: ____________________________ Phone #: ______________________ Relation: ________________
How did you learn of this clinic? ____

What is the purpose for this visit? ____
When did your symptoms start? ____

Indicate where you have pain or other symptoms below:



Rate your current discomfort on a scale of 1-10?

1 2 3 4 5 6 7 8 9 10

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)

How bad are your symptoms at their:

	None								Unbearable	
a. Worst:	1	2	3	4	5	6	7	8	9	10
b. Best:	1	2	3	4	5	6	7	8	9	10

How are your symptoms changing? □ Getting Better □ Not Changing □ Getting Worse

What describes the nature of your symptoms? (mark all that apply): □ Sharp □ Dull □ Aching □ Burning □ Numbing □ Shooting □ Tightness □ Throbbing □ Diffused □ Tingling □ Other: ____

What activities make your symptoms worse? ____

What activities make your symptoms better? ____

Is there a time of day when your discomfort is worse? □ N/A □ Morning □ Afternoon □ Evening □ Before bed

Have you seen anyone else for this condition? □ No □ Yes ____

Females Only: Are you pregnant? □ No □ Yes

Goals for my care:
□ **Relief**: symptomatic relief □ **Corrective**: correct cause and symptoms □ **Wellness**: highest state possible

For Office Use: Height: ___________ Weight: ___________ Blood Pressure: ____________ HR: ________

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First Name: ______________________________ **Last Name:** ______________________________ **Middle Initial:** _______

Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Social History					**Start Date (optional)**
Alcohol Use	□ Never	□ Occasional	□ Daily	□ Former	
Coffee Use	□ Never	□ Occasional	□ Daily	□ Former	
Tobacco Use	□ Never	□ Occasional	□ Daily	□ Former	
Exercise	□ Never	□ Moderate	□ Daily		

Are you currently taking any medications? (Include regularly used over the counter medications)		
Medication Name	Purpose (i.e. Blood Pressure)	Dosage & Frequency (i.e. 5 mg once a day)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

Family History (Record one diagnosis and the affected relative)			
Relative	Age (if living)	State of Health	Illness
		□ Good □ Poor	

Review of Systems (select all that you currently have or have suffered from in the past)

□ Neck Pain	□ Mid Back Pain	□ Lower Back Pain	□ Shoulder Pain	□ Arm/Hand Pain
□ Hip Pain	□ Leg/Foot Pain	□ Knee Pain	□ Headaches/Migraines	□ Dizziness
□ Vision Changes	□ Ringing in Ears	□ Hearing Loss	□ Arthritis	□ Disc Problems
□ Osteoporosis	□ Joint Swelling	□ Numbness	□ Scoliosis	□ Gout
□ Heart Problems	□ Stroke	□ High Blood Pressure	□ Weakness/Fatigue	□ Allergies
□ Diabetes	□ Insomnia	□ Digestive Problems	□ Gallbladder Problems	□ Urinary Problems
□ Kidney Problems	□ Cancer	□ STD	□ Depression	□ Tuberculosis

Patient Signature: ____ Date: __________/__________/__________

Provider Signature: ____ Date: __________/__________/__________

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Would you like us to file your visits here to your health insurance company? □ **Yes** □ **No**

Primary Insurance Provider: ______________________ **Policy #:** _________________________ **Group #:** _____________

Name as it appears on the card: _____________________________________ **1-800 #:** ____________________________

INSURANCE AGREEMENT:

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account on receipt. However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fess for professional services rendered to me will be immediately due and payable.

____ ____

Patient Signature Date Guardian or Spouse Signature Date

AUTHORIZATION FOR CARE:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she seems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

____ ____

Patient Signature Date Guardian or Spouse Signature Date

Who should receive bill for payment on account?

□ Self □ Spouse □ Parent □ Worker's Comp □ Medicare □ Personal Health Insurance □ Auto Insurance

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPPA) CONSENT:

Describes how health related information about you may be used and disclosed, and how you can get access to this information

In the course of your care as a patient at our office, we may use or disclose personal and health related information about you in the following ways: 1.) Your personal health information , including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. 2.) Your health records as well as your billing records may be disclosed to another party, such as an insurance carrier or your employer (if they are responsible for payment). 3.) Your name, address, phone number and your health records may be used to contact you regarding appointment reminders and a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with authorization, it will not affect the care provided to you. Under federal law we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. By signing below I acknowledge that I have read the above information and give full disclosure of my information.

Patient/Guardian Signature: ____ Date: ________/________/________

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