KEYSTONE
chiropractic

Dr. Donna J. Hedgepeth, DC, DACCP

NAME: _____ DATE: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (H) _____ (W) _____ (O) _____

Birth date: _____ / _____ / _____ Social Security #: _____ - _____ - _____

E-mail: _____ Marital Status: Single Married Other

Work Status: Employed/Unemployed/Self Employed Full Time/Part Time

Retired Student **Occupation: _____**

Employer: _____

Referred By: Friend Physician Name: _____

Phone Book Insurance Website Other

Insured's Name (if different from patient): _____

Insured's Employer: _____ Insured's Birth date: _____/_____/_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING BELOW.

I understand that if I am not eligible for coverage under the terms of the health plan that I have submitted to Keystone Chiropractic, I am liable for all charges for services and will pay when services are rendered or take advantage of a pre-paid plan. I understand that this office will only file to my primary health insurance and not to any secondary plans.

I authorize the release of any health information necessary to process this claim. A photocopy of this authorization shall be effective and valid as the original.

I authorize payment of medical benefits to Dr. Donna Hedgepeth, who accepts assignment through her contract with my health plan or representative.

I understand that I am responsible for deductibles, co-payments, co-insurance and services that exceed benefit limits as defined by my health plan. I understand that I am also financially responsible for all non-covered services, including care determined to be elective or maintenance. In cases where services are billed to Workers Compensation or my Attorney, I understand that I am financially responsible for said charges.

I agree to notify the office of Dr. Donna Hedgepeth immediately of any change in insurance coverage. I will be responsible for any charges not considered by insurance as a result of changes in coverage without notification by me. I authorize payment directly to Keystone Chiropractic, the office of Dr. Donna Hedgepeth.

Patient Signature: _____ Date: ____/____/_____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

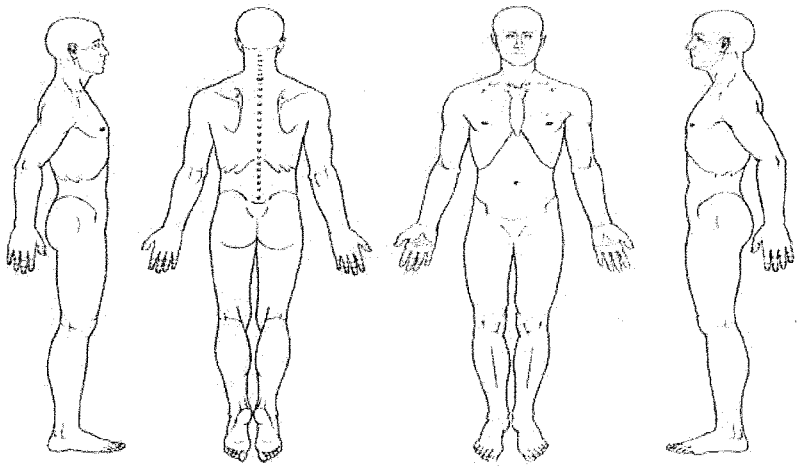
a. When did your symptoms start? _____

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 Other 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 Other 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

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
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	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* _____

ACCCIDENT INFORMATION

Date of Accident:_____ **Time:**_____ **Location:**_____

Was police report made? YES NO

Was the vehicle you were in: STOPPED IN MOTION

You were: DRIVING A PASSENGER **In a:** CAR TRUCK BUS OTHER:_____

Were you wearing a seat belt? YES NO

The vehicle you were in: STRUCK WAS STRUCK **By a:** CAR TRUCK BUS OTHER:_____

Your vehicle sustained damage to the: REAR FRONT LEFT SIDE RIGHT SIDE

At the time of the collision, were you looking: FORWARD UP DOWN LEFT RIGHT

At the time of collision, were you: SITTING UPRIGHT/FACING FORWARD

BENDING DOWN TURNING TO THE LEFT

TURNING TO THE RIGHT DON'T REMEMBER

Due to the impact, were you thrown: BACKWARD FORWARD

TO THE LEFT TO THE RIGHT

You struck your (list body parts)_____
against the : STEERING WHEEL DASHBOARD OTHER:_____

Did you suffer any dislocations?	YES	NO
Cuts?	YES	NO
Bumps?	YES	NO
Bruises?	YES	NO

Were you rendered unconscious? YES NO

Were you able to get out and walk from your vehicle unattended? YES NO

What symptoms did you experience the day of the accident?

_____

_____

Have you had any medical diagnosis or treatment performed since the day of the accident?
NO YES: **When?**_____ **Where:**_____
When?_____ **Where:**_____

Have you missed any work? NO YES: FROM_____TO_____

List your present complaints in the order of their severity (most sever first). Please be specific in listing not only the location (i.e. neck, upper back, leg, etc.) but also the type of complaint (i.e. pain, stiffness, etc.)

1._____ **2.** _____

3. _____ **4.** _____

Did you have previous/similar symptoms prior to the accident? NO YES:_____

_____ _____-_____-_____ _____

PATIENT'S SIGNATURE **S.S. NUMBER** **DATE**