



KEYSTONE
chiropractic

Dr. Donna J. Hedgepeth, DC, DACCP

PARENT'S FULL 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 _____

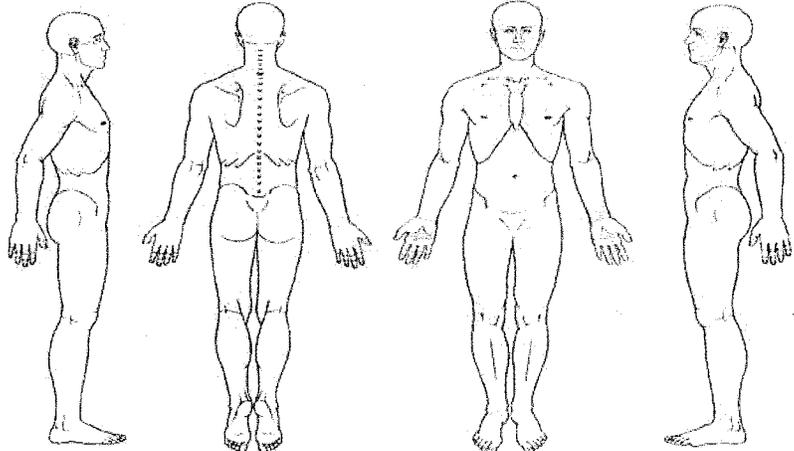
1. Describe your symptoms _____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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 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: _____
- ② MRI date: _____
- ③ CT Scan 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 _____