



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

Employer & Occupation: _____

Referred By: Friend Physician Name: _____

Phone Book Insurance Website Other

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

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

Prior Pregnancy: Yes No

Birth Description: Vaginal Cesarean

Medications/Fertility Treatments: _____

Complications: _____

Current Pregnancy: **Due Date:** ____/____/____

Any current diagnosed disorders (ie diabetes/hypertension): _____

Medications/Supplements: _____

Bowel/Bladder Movements: Regular Irregular

Sleeping Schedule: _____

Complaints: _____

Any other treatment to date: Yes No

If yes, outcome: _____

OB/GYN or Midwife: _____ **Phone:** _____

Doula: _____ **Phone:** _____

Any other provider: _____ **Phone:** _____

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 _____

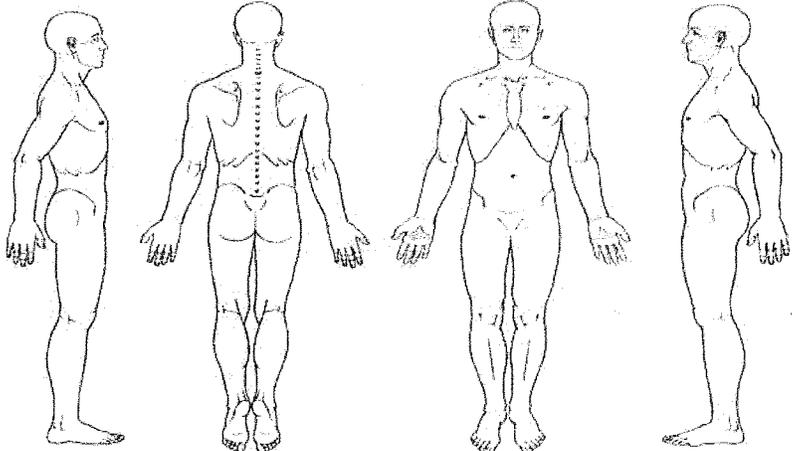
1. Describe your symptoms _____

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 Unbearable ⑩

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

Females Only

Birth Control Pills
 Hormonal Replacement
 Pregnancy

Other Health Problems/Issues

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 _____