PARADISE VILLAGE CHIROPRACTIC CENTER
CHIROPRACTIC • ACUPUNCTURE • REHABILITATION • FUNCTIONAL MEDICINE • SPORTS THERAPY
13835 N. Tatum Blvd. Ste. 3, Phoenix, AZ 85032 Phone: (602) 953-1900 Fax: (602) 953-1901

Confidential Patient Information

Please Print, there are two sides, please fill out the front and back

Name: _____

Address:_____

City:_____ ST:_____ Zip: _____

Phone: (_____)_____

Cell Phone: (_____)_____

Age: _____ Date of Birth: _____

Email: _____

Occupation: _____

Employer:_____

Employer Address: _____

_____

Office Phone:(_____)_____

Marital Status: (S) (M) (W) (D) Children:_____

Name of Spouse:_____ Occupation:_____

Spouse's Employer:_____ Phone: (_____)_____

How were your referred to this office?_____

Purpose of this appointment?_____

Other doctors seen for this condition?_____

Did Accident/Injury occur at work? (NO) (YES) Date:_____ Time:_____

Was it reported? (NO) (YES) If so to whom? _____

Were you involved in an Auto Accident? (NO) (YES) Date:_____

Name of Primary Care Physician: _____ Phone (_____)_____

Have you been treated for any other health condition in the past year? (NO) (YES)

If yes, please describe:_____

When was your last physical exam?_____ Laboratory testing? _____

OVER

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature:_____ Date:_____

Parent/Guardian Signature Authorizing Care: _____

Information taken by:_____ Date:_____

CONSENT FOR TREATMENT

X_____ I acknowledge and understand that in presenting myself for treatment and continuing care at Paradise Village Chiropractic Center, that I authorize and consent to the administration and performance of tests and treatments which may be ordered by the physician or designated assistant and carried out by members of this office staff.

REGARDING INSURANCE

X_____ We are in and out of network with various insurance companies. Please ask the receptionist if your insurance company is included. Participation is subject to change. Please be aware some, perhaps all, of the services provided may be non-covered services and this will be the patient's responsibility. All deductibles and co-pays are due at the time of service.

USUAL AND CUSTOMARY RATES

X_____ Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with the company.

PAYMENT AGREEMENT

I hereby assume full responsibility for and agree to pay all costs, charges and expenses incurred as the patient, to Paradise Village Chiropractic Center/Functional Health Systems S.C. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not contingent upon payment of any such costs, charges or expenses by any third party. An assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed a waiver of the provider's right to require payment directly, from the undersigned. The provider expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all cost of collection, including but not limited to reasonable attorney fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several.

I understand that this office has a $25.00 administrative fee added to my bill each month my balance is outstanding. Outstanding balances include unpaid deductibles, co-payments or patient portions.

Signature of Patient or Responsible Party **Date**

Patient Name (Printed) **Date of Birth**

Patient Health Questionnaire - PHQ

Paradise Village Chiropractic Center
13835 N. Tatum Blvd. Ste 3
Phoenix, AZ 85032

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

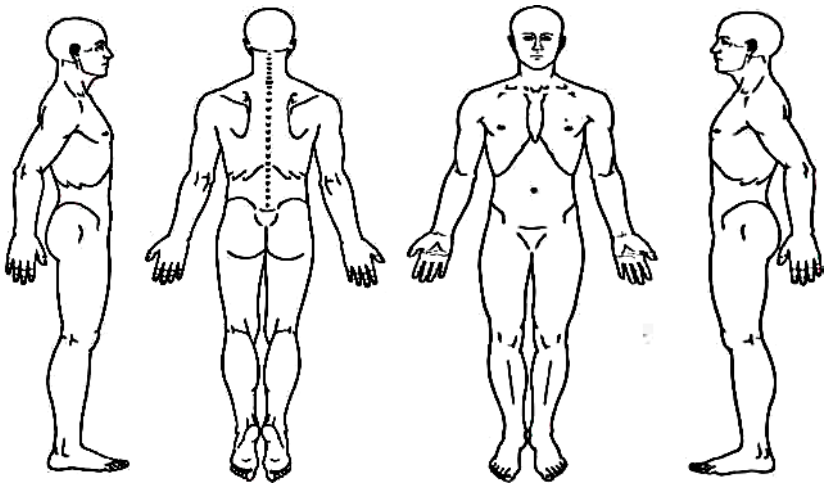
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- ○ 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. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None *Unbearable*

0 1 2 3 4 5 6 7 8 9 10

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ 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)

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

7. In general would you say your overall health right now is...

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

8. Who have you seen for your symptoms?

○ No One ○ Medical Doctor ○ Other
○ Chiropractor ○ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

○ Xrays *date:* _____ ○ CT Scan *date:* _____
○ MRI *date:* _____ ○ Other *date:* _____

9. 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 ○ Medical Doctor ○ Other
○ Chiropractor ○ Physical Therapist

10. What is your occupation?

_____

○ Professional/Executive ○ Laborer ○ Retired
○ White Collar/Secretarial ○ Homemaker ○ Other
○ Tradesperson ○ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

○ Full-time ○ Self-employed ○ Off work
○ Part-time ○ Unemployed ○ Other

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

Paradise Village Chiropractic Center
13835 N. Tatum Blvd. Ste 3
Phoenix, AZ 85032

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ 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
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	***Other Health Problems/Issues***		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	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*** _____

Provider's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____