PATIENT INTRODUCTION FORM

Today's Date	
Patient Name: Last	**First** **Middle Init.**
Address:	Home Telephone:
City/Zip:	Work Telephone:
Date Birth: Age:	Cell:
Referred By:	Employer's Name:
Social Security No.	Occupation:
E-mail Address:	Marital Status (Circle): Single, Married, Divorced, Widowed

Would you like to receive **FREE** e-mail from Dr. Gillett's "To Your Health" Newsletter? ❒ Yes ❒ No

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

_____

IS THIS VISIT RELATED TO A:

- ❒ Work Related Injury
- ❒ Home Injury
- ❒ Non-Injury Symptons
- ❒ Car Crash Injury
- ❒ Other (Describe):
- ❒ Motorcycle-Bicycle Injury
- ❒ Sports Injury
- ❒ Check-up Only
- ❒ School/Employment Physical
- ❒ Pedestrian Injury

Main Complaint: _____

Date problem started: _____

Does your insurance cover Chiropractic treatment?	❒ Yes, ❒ No
If yes, indicate Insurance Company Name (Need copy of card)	Name:
Are you the insured person or dependent (wife/husband/child)?	❒ Insured, ❒ Dependent
If you are the insured persons dependent, we need insured persons name, social security number, the name of the employer's business and date of birth.	Name of Insured Person: Social Security Number: Name of Insured Business: Date of Birth:

I hereby authorize my insurance benefits to Optimal Chiropractic Clinic and authorize release of any information to any insurance company, adjustor or attorney involved in this care. A photocopy of this authorization shall be considered as valid as the original. I authorize payment directly to Optimal Chiropractic Clinic.

Signature of responsible party (Patient or Parent)_____ Date _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2002

Patient Name _____ Date _____

1. Describe your symptoms _____

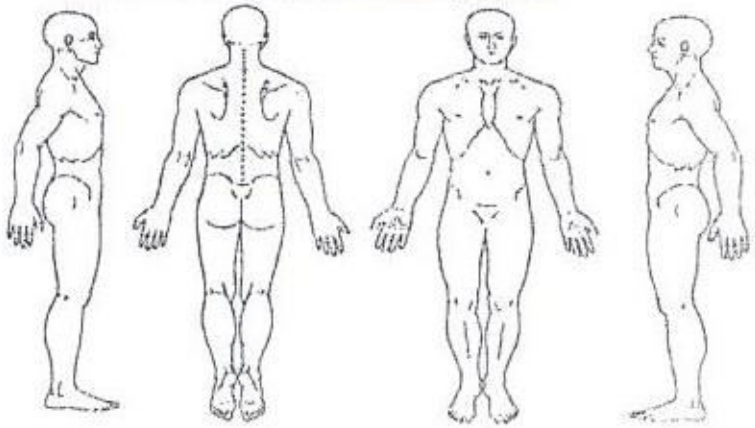
_____

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 ③ Medical Doctor ⑤ Other
   ② Other Chiropractor ④ Physical Therapist

   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 ③ Medical Doctor ⑤ Other
   ② Other Chiropractor ④ Physical Therapist

10. What is your occupation?
    ① Professional/Executive ④ Laborer ⑦ Retired
    ② White Collar/Secretarial ⑤ Homemaker ⑧ Other
    ③ Tradesperson ⑥ FT Student

    a. If you are not retired, a homemaker, or a student, what is your current work status?
    ① Full-time ③ Self-employed ⑤ Off work
    ② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ Date _____

REVIEW OF SYSTEMS

Patient instructions: Please circle any condition that you are currently experiencing or have in the past year.

General:	Fever	Chills	Allergies
	Weight Loss	Fatigue	Changes in Daily Routine
	Weight Gain	Night Sweats	Nausea
	Poor Appetite	Forgetfulness	Excessive Thirst
	Hoarseness	Nervousness	Excessive Stress
	Cancer	HIV/AIDS	Other:
Head:	Headache	Trauma	Loss of Consciousness
	Other:		
Eyes:	Contacts	Blurry Vision	Double Vision
	Glasses	Light Sensitivity	Flashes in Front of Eyes
	Cataracts	Spots in Vision	Glaucoma
	Other:		
Ears:	Ringing in Ears	Hearing Loss	Pain
	Drainage	Frequent Infections	Other:
Nose:	Sinus Problems	Post Nasal Drip	Nose Bleeds
	Other:		
Mouth:	Gum Bleeds	Cold Sores	Jaw Pain
	Dentures	Swelling	Difficulty Swallowing
	Changing in Taste	Sore Throat	Dental Problems
Neck:	Masses	Stiffness	Swelling
	Other:		
Lungs:	Cough	Coughing up Blood	Coughing up Sputum
	Pneumonia	Wheezing	Asthma
	Emphysema	Other:	
Vascular:	Chest Pain	Swelling	Calf Pain
	Palpitations	Varicose Veins	Poor Circulation
	Rapid Heartbeat	Irregular Heartbeat	Pulsations in Abdomen
	Hepatitis	Stroke	Congenital Heart Defect
	Anemia	Diabetes	Heart Surgery/Pacemaker
		High/Low blood pressure	Other:
Gastro-Intestinal:	Gas/Bloating	Vomiting	Heartburn
	Diarrhea	Constipation	Black/Bloody Stool
	Difficult Digestion	Abdominal Pain	Hemorrhoids
	Bowel Changes	Rectal Bleeding	Ulcers/Colitis
	Other:		

Genital Urinary:	Difficult Urination	Decreased Urination	Increased Urination
	Foul Odor of Urine	Blood in Urine	Urinary Tract Infection
	Incontinence	Pain with Urination	Kidney Stones
	STD	Other:	
Men:	Prostate Dysfunction	Sexual Dysfunction	Lump(s) in Testicle
	Sore Penis	Penis Discharge	Other:
Women:	Hysterectomy	PMS	Lump(s) in Breast
	Pregnancy	Mastectomy	Discharge from Nipple
	Vaginal Discharge	Hot Flashes	Bleeding between Periods
	Extreme Menstruation	Last Breast Exam:	Other:
Skin:	Rash	Warts	Itching
	Brushing	Hair Loss	Brittle Nails
	Changes in Moles	Other:	
Neurology:	Seizures	Numbness	Tingling Sensation
	Weakness	Paralysis	Difficulty Walking
	Fainting	Dizziness	Convulsions
	Shingles	Other:	
Musculo-Skeletal:	Joint Pain	Fractures	Dislocation
	Stiffness	Deformities	Bone Pain
	Muscle Ache	Artificial Bones/Joints	Other:
Psychiatric:	Confusing	Depression	Mood Swings
	Anxiety	Other:	
Social History:	Consume Coffee	Exercise Regularly	Smoker Past/Present
	Drug/Alcohol Abuse	Other:	

Immediate Family History:

Diabetes	(Who_____)	Stoke	(Who_____)	HBP	(Who_____)
Heart Disease	(Who_____)	Arthritis	(Who_____)	ALS	(Who_____)
Back Problems	(Who_____)	Cancer	(Who_____)	Lupus	(Who_____)

I certify that the information Is correct to the best of my knowledge. I will not hold my doctor nor any members of his or her staff to be responsible for any omissions from this form.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care and I give consent for these procedures to be performed. The doctor will not be held responsible for any pre-existing medically diagnosed condition nor for any medical diagnosis.

_____ _____

Patient/Parent Signature Date

OPTIMAL CHIROPRACTIC

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights will be provided to you upon your request.

Optimal Chiropractic uses health information about you for treatment, to obtain payment for your treatment with your authorization as requested, for administrative purposes, and to evaluate the quality of the care you receive.

Optimal Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorized or requires us to do so.

Optimal Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Optimal Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Optimal Chiropractic must maintain the privacy of protected health information, provide you with a notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact our office at 303-427-2225.

_____ _____

Patient or legally authorized signature Date