Advanced Spine and Headache Center
21751 W. 11 Mile Rd. Suite 110, Southfield, MI 48076
Phone: 248-356-2100 Fax: 248-356-2121

Patient Information Form

Mr/Mrs/Ms

Last Name: _____
First Name: _____
Mid Init: _____

Address: _____
City: _____
State: _____
Zip Code: _____

Home Phone: _____
Cell Phone: _____

Birth Date: _____
Social Security: _____

Single Married Divorced Widowed

Primary Insurance

Name of Insurance: _____
Contract or Claim #: _____
Group #: _____
Adjuster Name and Phone #: _____

Secondary Insurance

Name of Insurance: _____
Contract or Claim #: _____
Group #: _____
Adjuster Name and Phone #: _____

Assignment & Release

I, the undersigned, have insurance coverage with _____ and assign payment directly to Advanced Spine and Headache Center all medical benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. **PRIVACY PRACTICES ACKNOWLEDGEMENT.** I have received the **Notice of Privacy Practices** and I have been provided with an opportunity to review it.

_____ _____
Signature of insured/guardian Date

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

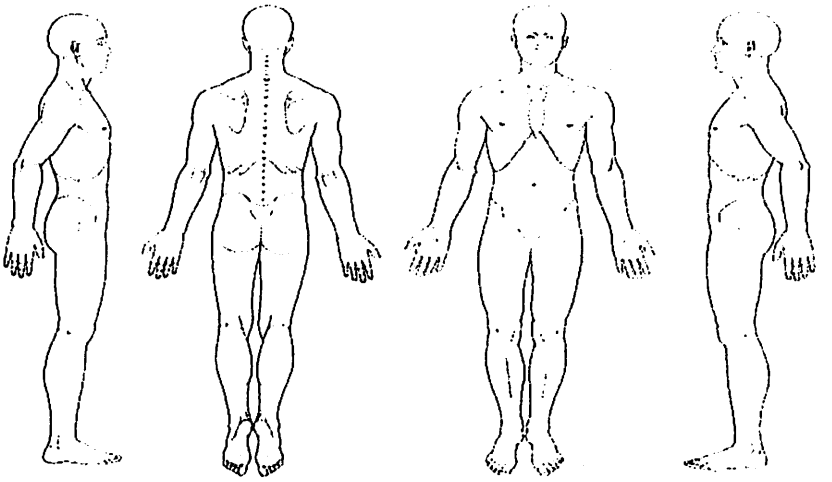
_____

_____

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. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

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:* _____

10. 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

11. 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

12. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

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 [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

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** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____

ADVANCED SPINE AND HEADACHE CENTER

FINANCIAL POLICY

Dear Patient,

Thank you for choosing Advanced Spine and Headache Center for your healthcare needs. Please take a moment to review our financial policy below.

Please note that **your primary health insurance, and/or no-fault personal injury protection benefits (when applicable), are not a guarantee of payment** for treatment rendered, and **you, the patient, are responsible to verify your own benefits** as well. Your exact benefit amount is determined after we bill your insurance carrier and actually receive an explanation benefits from them. *You will receive the same explanation from your insurance company describing your exact dollar amount owed.*

You are required to pay the co-payment / deductible at the time of your office visit each time you are seen. If you are not prepared to pay that amount, you should reschedule your visit unless other arrangements have been made with the office manager. You will be billed for all unpaid charges. If you do not understand your statement balance, please call your office for an explanation of charges on the statement.

If you are seeking treatment at our facility for an Auto or Work related accident which occurred on or about _____, by signing this policy, you the patient, give a lien for the total amount outstanding to Advanced Spine and Headache Center on any settlement, claim, law suit, judgment or verdict as a result of aforementioned accident, and authorize and instruct your attorney, and/or insurance company, to pay directly to Advanced Spine and Headache Center all such sums as may be due and owing to Advanced Spine and Headache Center for services rendered to me, and to withhold such sums from such settlement, law suit, claim, judgment or verdict, as may be necessary to fully protect Advanced Spine and Headache Center. ***Please note that this lien will supersede any attorney lien.***

I specifically agree that disbursement of any proceeds to me shall not take place unless and until Advanced Spine and Headache Center has been paid in full for treatment rendered.

I fully read and understand that I am personally and fully responsible to Advanced Spine and Headache Center for all chiropractic/medical bills submitted by Advanced Spine and Headache Center for services rendered to me and this agreement is made solely for Advanced Spine and Headache Center's additional protection and in consideration awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said charges for treatment.

Missed Appointment Policy:

As a consideration to other patients we encourage you to keep your appointment time, however, **please note that you will be charged $75(dollars) if you do not show up or cancel your appointment 3 hours prior to your appointment time**.

Patient Name: _____ Date: _____

Patient Signature: _____

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