# PLADSON-LAU CHIROPRACTIC CLINIC, P.A

420 Center Ave., Suite 48 Moorhead, MN 56560
Phone 218-236-5151 Fax 218-236-5866

## Patient Information

First Name _____ MI ____ Last Name _____ Sex

Address_____ City _____ State _____ Zip _____

Birth Date _____ SSN _____ Phone _____

Email _____ Referred by _____

Marital Status _____ Spouse's Name _____ Number of Children _____

Employer _____ Occupation _____

Employer Address _____ Work Phone _____

## Who is financially responsible?

First & Last Name _____ Relationship _____ Phone _____

Address_____ City _____ State _____ Zip _____

## Patient Financial Responsibilities:

- The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you, however the patient is required to provide current and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatments not covered or approved by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Parent or guardian must sign if patient is under 18 years of age.

Signature: _____ Date: _____

# Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

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

**Patient Name** _____ **Date** _____

**1. Describe your symptoms** _____

_____

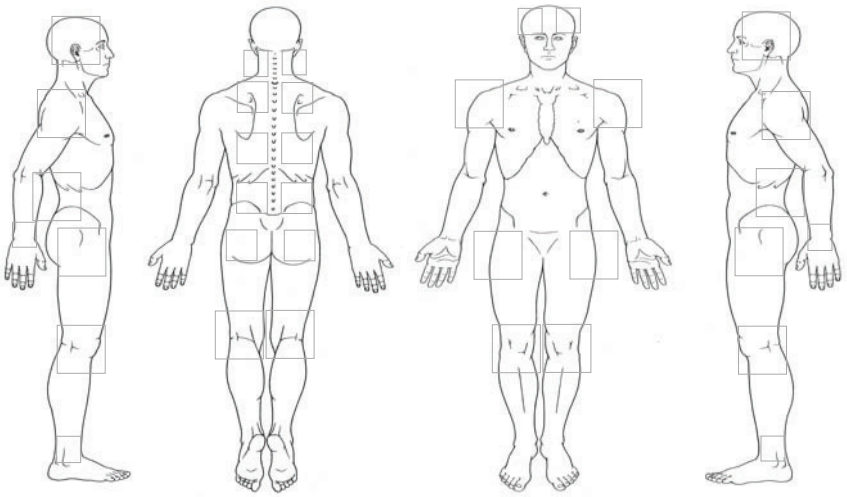
*a. When did your symptoms start?* _____

*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 <u>past 4 weeks:</u>**

*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)*

◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

**6. During the <u>past 4 weeks</u> 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

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**8. Who have you seen for your symptoms?**

◯ No One ◯ Medical Doctor ◯ Other
◯ 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
◯ 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 Name** _____ **Date** _____

**Race:** _____ **Ethnicity:** _____ **Language Preferred:** _____

**What are your height and weight?** Height: ____ ft ____ in Weight: _____ lbs

**What type of regular exercise do you perform?** ◯ None ◯ Light ◯ Moderate ◯ Strenuous

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**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 / Migraines | ☐ | ☐ | Spinal Cord Injury | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Neck Pain | ☐ | ☐ | Genetic Spinal Disorder | ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Upper Back Pain | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ | Smoking/Use of Tobacco |
| ☐ | ☐ | Mid Back Pain | ☐ | ☐ | Parkinson's disease | ☐ | ☐ | Alcohol Use/Dependence |
| ☐ | ☐ | Low Pack Pain | ☐ | ☐ | Dizziness / Fainting | ☐ | ☐ | Drug Use/Dependence |
| ☐ | ☐ | Shoulder / Upper Arm Pain | ■ | ■ | High Blood Pressure | ☐ | ☐ | Depression |
| ☐ | ☐ | Elbow Pain | ☐ | ☐ | Atrial Fibrillation | ☐ | ☐ | Mental Health Disorder |
| ☐ | ☐ | Wrist Pain | ☐ | ☐ | Heart Attack / Stroke | ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Chest Pains / Angina | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Hip Pain | ☐ | ☐ | Kidney Stones / Disorders | ☐ | ☐ | Dermatitis/Eczema/Rash |
| ☐ | ☐ | Upper Leg Pain | ☐ | ☐ | Bladder Infection | ☐ | ☐ | Allergies |
| ☐ | ☐ | Knee Pain | ☐ | ☐ | Painful Urination | Please list any allergies | | |
| ☐ | ☐ | Lower Leg Pain | ☐ | ☐ | Frequent Urination | _____ | | |
| ☐ | ☐ | Ankle Pain | ☐ | ☐ | Loss of Bladder/Bowel Ctrl | _____ | | |
| ☐ | ☐ | Foot Pain | ☐ | ☐ | Prostate Problems | _____ | | |
| ☐ | ☐ | Jaw Pain | ☐ | ☐ | Abnormal Weight Gain/Loss | Females Only | | |
| ☐ | ☐ | Joint Swelling/Stiffness | ☐ | ☐ | Loss of Appetite | ☐ | ☐ | Pregnancy |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Abdominal Pain | ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | Ulcer | ☐ | ☐ | Birth Control Pills |
| ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Hepatitis | ☐ | ☐ | Menstrual Problems |
| ☐ | ☐ | General Fatigue | ☐ | ☐ | Liver/Gall Bladder Disorder | ☐ | ☐ | _____ |
| ☐ | ☐ | Muscular Incoordination | ☐ | ☐ | Cancer | Other Health Problems/Issues | | |
| ☐ | ☐ | Visual Disturbances | ☐ | ☐ | Tumor | ☐ | ☐ | _____ |
| ☐ | ☐ | Hearing Problems | ☐ | ☐ | Asthma | ☐ | ☐ | _____ |
| ☐ | ☐ | Ear Infection | ☐ | ☐ | Chronic Sinusitis | ☐ | ☐ | _____ |

**Indicate if an immediate family member has had any of the following:**

Circle M if Mother's Side and F for Father's side and please indicate your relationship to the family member affected.

| | | |
|---|---|---|
| ☐ Rheumatoid Arthritis | ☐ Heart Problems | ☐ Diabetes |
| M ◯ F ◯ _____ | M ◯ F ◯ _____ | M ◯ F ◯ _____ |
| ☐ Cancer | ☐ Lupus | ☐ _____ |
| M ◯ F ◯ _____ | M ◯ F ◯ _____ | M ◯ F ◯ _____ |

**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:**

_____ _____ _____

_____ _____ _____

**Doctor Signature** _____ **Date** _____

# Privacy Notice to Patients

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

1. This clinic may use and/or disclose your medical information consistent with a valid consent granted by you for the purpose of:

a. Treatment – In order to provide you with the healthcare you require, this clinic will provide your medical information to those healthcare professionals, whether on this clinic's staff or not, directly involved in your care so they may understand your medical condition and needs;

b. Payment – In order to get paid for services provided, this clinic will provide your medical information, directly or through a billing service, to appropriate third party payers, as per their billing and payment requirements; and

c. Healthcare operations – In order to gain an overall view of various elements of this clinic's operations, individual medical information may be collected, compiled and disseminated.

2. This clinic may use and/or disclose your medical information, without consent, in the following instances:

a. De-identified information – Information that is not individually identifiable, in accordance with applicable law, may be freely disclosed by this clinic.

b. Business Associate – If this clinic obtains satisfactory written assurance from the business associate, in accordance with the applicable laws, that the business associate with appropriately safeguard the protected information;

c. Personal Representative – If under applicable Minnesota law a person has the authority to represent you in making decisions.

d. Emergency Situations –
   - For the purpose of obtaining emergency treatment to you, if the clinic attempts to obtain consent but is unable to do so;
   - To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities;

e. Communication Barriers – If, due to substantial communication barriers or inability to communicate, this clinic has been unable to obtain consent and this clinic determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances;

f. Involvement in Care or Payment – In accordance with applicable laws, disclosure may be made to your family member, other relative, close friend and/or any other person identified by you, of such information that is relevant to the person's involvement with your care or payment related to your healthcare;

g. Notification – In order to notify or assist in the notification of a family member, a personal representative or another responsible for your care of your location or general condition;

h. Required by law – When and to the extent that such disclosure is required by law, complies with and is limited to the relevant requirements of such law;

i. Criminal Conduct- To a law enforcement official, that this clinic believes in good faith contributes evidence of criminal conduct that occurred on the clinic premises;

j. Threat to health and/or safety – If it is necessary to prevent or lessen a serious and imminent threat to the health and/or safety of a person or the public, in accordance with applicable laws; and

k. Thank you cards or birthday cards.

3. Other uses and/or disclosures with be made only with your written authorization.

4. Your Rights – You have the right to:
   a. Revoke any authorization and/or consent, in writing, at any time;
   b. Request restrictions on certain uses and/or disclosures as provided by law; however this clinic is not obligated to agree to any requested restrictions.
   c. Receive confidential communications or protected information as required by law;
   d. Inspect and copy protected information as provided by law;
   e. Amend protected information as provided by law;
   f. Receive an accounting of disclosures of protected information as provided by law;
   g. To receive a paper copy of this notice from this clinic upon requested;
   h. To complain to this clinic or to the Secretary of HHS if you believe your privacy rights have been violated. Please see your Social Worker to file a complaint; and
   i. To obtain more information on, or have your questions about your rights answered; you may contact this clinic's Privacy Officer, Dr. Jeff Pladson, at 218-236-5151.

5. Clinic Rights & Requirements- This clinic:
   a. Is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected information;
   b. Is required to abide by the terms of this notice;
   c. Reserves the right to change the terms of this notice and to make the notice provisions effective for all protected information that it maintains.
   d. Will:
      - Distribute any revised notice at or before an appointment at the clinic prior to implementation; and
      - Give to you, and you will be required to sign a receipt for, any revised notice.
   e. Will not retaliate against you for filing a complaint.

6. This original notice is in effect as of 04/14/2003

**I have received and reviewed this notice.**

**Notice received by (print name) _____**

**Signature of Recipient: (sign name) _____**

**Date Receive: _____/_____/_____**