THE ARNE CLINIC
Chiropractic and Natural Medicine
12991 Ridgedale Drive, Minnetonka, MN 55305 | (952) 541-0200 | bewell@arneclinic.com

PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Address: _____ City: _____ State: ____ Zip: _____

Mobile Phone: _____ Work Phone: _____ Home Phone: _____

Email: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Minor Patient Parent/Guardian Name: _____ Phone: _____

HOW DID YOU HEAR ABOUT US? (check all that apply)

□ Individual/Patient: _____

□ Internet Search □ Building/Sign/Location □ The Arne Clinic Website □ Facebook □ Advertisement

□ Other (Physician/Attorney/Employer/etc.): _____

PURPOSE OF THIS VISIT

Reason for this visit/main complaint: _____

Is this visit related to an auto accident or work injury? □ YES □ NO If so, when: _____

EXPERIENCE WITH CHIROPRACTIC

Have you been seen by a chiropractor before? □ YES □ NO When: _____ Who: _____

Reason: _____ How did you respond to treatment: _____

HEALTH CARE GOALS (check all that apply)

□ I want relief from a specific health concern.

□ I want to ensure that my health concerns do not become an ongoing problem.

□ I am interested in learning more about improving my overall health.

□ Other: _____

FINANCIAL STATEMENT/PAYMENT POLICY & AUTHORIZATION

I understand that I am responsible to pay for services and supplies at the time of service. Any balance billed from our office deemed 'patient responsibility' exceeding 60 days past due will be assessed an 8% interest charge.
Auto Accident and Workers Compensation: If the incident is properly documented and the necessary forms and liens are signed, you are not required to pay for services on the day they are rendered, and we will make efforts to file your services with your insurance provider for you. You are still responsible for all charges on your account.

Patient Signature: _____ Date: ____/____/____

Optional Card Payment Authorization: I, the undersigned patient, hereby authorize The Arne Clinic to initiate debit/credit card charges to my account with my financial institution for payment of service(s) and product(s) rendered to me in the amount due. I understand that the authorization is to remain in effect indefinitely and may be withdrawn by me at any time by request.

Patient Signature: _____ Date: ____/____/____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

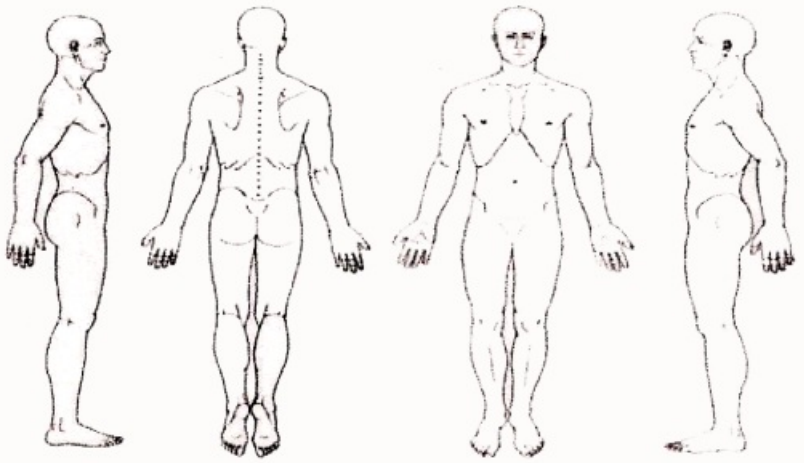
a. When did your symptoms start? _____

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 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 Chiropractor ④ Physical Therapist

10. What is your occupation?

_____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑨ 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** _____

Patient Health Questionnaire - page 2

ChiroCare Use Only

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ①None ②Light ③Moderate ④Strenuo

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ]
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	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke			
O	O	Low Back Pain	O	O	Angina	O	O	Smoking/Use Tobacc
						O	O	Drug/Alcohol Depend
O	O	Shoulder Pain	O	O	Kidney Stones			
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders	O	O	Allergies
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Depression
O	O	Hand Pain	O	O	Painful Urination	O	O	Systemic Lupus
			O	O	Loss of Bladder Control	O	O	Epilepsy
O	O	Hip/Upper Leg Pain	O	O	Prostate Problems	O	O	Dermatitis/Eczema/R
O	O	Knee/Lower Leg Pain				O	O	HIV/AIDS
O	O	Ankle/Foot Pain	O	O	Abnormal Weight Gain/Loss			
			O	O	Loss of Appetite	*Females Only*		
O	O	Jaw Pain	O	O	Abdominal Pain	O	O	Birth Control Pills
			O	O	Ulcer	O	O	Hormonal Replaceme
O	O	Joint Swelling/Stiffness	O	O	Hepatitis	O	O	Pregnancy
O	O	Arthritis	O	O	Liver/Gall Bladder Disorder	O	O	
O	O	Rheumatoid Arthritis						
			O	O	Cancer	*Other Health Problems/Issue*		
O	O	General Fatigue	O	O	Tumor	O	O	
O	O	Muscular Incoordination				O	O	
O	O	Visual Disturbances	O	O	Asthma	O	O	
O	O	Dizziness	O	O	Chronic Sinusitis			

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

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O _____

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**