



WELCOME

Dr. Mark A. Grumet and Integrated Chiropractic of the North Shore, LLC welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to determine if we can assist you.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

PATIENT IDENTIFICATION

Name _____	Telephone (Home) _____
(Last) (First)	(Work) _____
Street _____	Email address _____
City, State and Zip _____	Occupation _____
Social Security # _____	Date of Birth _____ Age _____
Male () Female ()	
Contact in case of emergency, Name: _____	
Telephone # _____	
Name of Parent of Minor Patient (If applicable) _____	
Referred By: _____	Name of Primary Care Doctor: _____
File No: _____	Location or phone number: _____
(For office use only)	

ACCEPTANCE AS PATIENT

I understand and agree that **Dr. Mark A. Grumet and Integrated Chiropractic of the North Shore, LLC** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Date

Signature

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

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

Patient Name _____

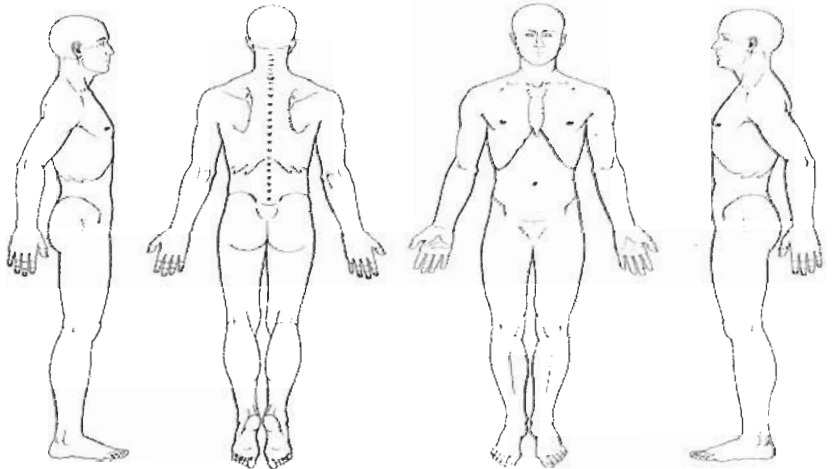
Date _____

1. When did your symptoms start: _____

Describe your symptoms and how they began:

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



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: ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

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

- | | | | | | | | | | |
|---------------|-------------------------------|------------------------------------|----------------------------------|--|------------------------------|---|---|---|---|
| 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
- ③ Medical Doctor
- ⑤ Other
- ② Other Chiropractor
- ④ Physical Therapist

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
- ③ Medical Doctor
- ⑤ Other
- ② Other Chiropractor
- ④ Physical Therapist

11. 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

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

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

Patient Signature _____

Date _____

