



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) _____	(Work) _____
(First) _____	
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 _____

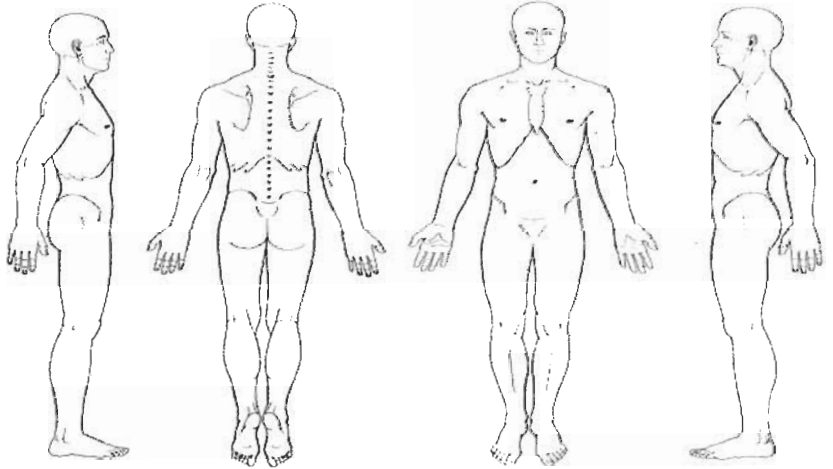
Date _____

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 _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

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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

--	--	--

 Weight

--	--	--

 lbs.
Foot 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.

- | | | |
|---|--|--|
| <p>Past Present</p> <p><input type="radio"/> <input type="radio"/> Headaches</p> <p><input type="radio"/> <input type="radio"/> Neck Pain</p> <p><input type="radio"/> <input type="radio"/> Upper Back Pain</p> <p><input type="radio"/> <input type="radio"/> Mid Back Pain</p> <p><input type="radio"/> <input type="radio"/> Low Back Pain</p>
<p><input type="radio"/> <input type="radio"/> Shoulder Pain</p> <p><input type="radio"/> <input type="radio"/> Elbow/Upper Arm Pain</p> <p><input type="radio"/> <input type="radio"/> Wrist Pain</p> <p><input type="radio"/> <input type="radio"/> Hand Pain</p>
<p><input type="radio"/> <input type="radio"/> Hip/Upper Leg Pain</p> <p><input type="radio"/> <input type="radio"/> Knee/Lower Leg Pain</p> <p><input type="radio"/> <input type="radio"/> Ankle/Foot Pain</p>
<p><input type="radio"/> <input type="radio"/> Jaw Pain</p>
<p><input type="radio"/> <input type="radio"/> Joint Swelling/Stiffness</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p> <p><input type="radio"/> <input type="radio"/> Rheumatoid Arthritis</p>
<p><input type="radio"/> <input type="radio"/> General Fatigue</p> <p><input type="radio"/> <input type="radio"/> Muscular Incoordination</p> <p><input type="radio"/> <input type="radio"/> Visual Disturbances</p> <p><input type="radio"/> <input type="radio"/> Dizziness</p> | <p>Past Present</p> <p><input type="radio"/> <input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> <input type="radio"/> Heart Attack</p> <p><input type="radio"/> <input type="radio"/> Chest Pains</p> <p><input type="radio"/> <input type="radio"/> Stroke</p> <p><input type="radio"/> <input type="radio"/> Angina</p>
<p><input type="radio"/> <input type="radio"/> Kidney Stones</p> <p><input type="radio"/> <input type="radio"/> Kidney Disorders</p> <p><input type="radio"/> <input type="radio"/> Bladder Infection</p> <p><input type="radio"/> <input type="radio"/> Painful Urination</p> <p><input type="radio"/> <input type="radio"/> Loss of Bladder Control</p> <p><input type="radio"/> <input type="radio"/> Prostate Problems</p>
<p><input type="radio"/> <input type="radio"/> Abnormal Weight Gain/Loss</p> <p><input type="radio"/> <input type="radio"/> Loss of Appetite</p> <p><input type="radio"/> <input type="radio"/> Abdominal Pain</p> <p><input type="radio"/> <input type="radio"/> Ulcer</p> <p><input type="radio"/> <input type="radio"/> Hepatitis</p> <p><input type="radio"/> <input type="radio"/> Liver/Gall Bladder Disorder</p>
<p><input type="radio"/> <input type="radio"/> Cancer</p> <p><input type="radio"/> <input type="radio"/> Tumor</p> <p><input type="radio"/> <input type="radio"/> Asthma</p> <p><input type="radio"/> <input type="radio"/> Chronic Sinusitis</p> | <p>Past Present</p> <p><input type="radio"/> <input type="radio"/> Diabetes</p> <p><input type="radio"/> <input type="radio"/> Excessive Thirst</p> <p><input type="radio"/> <input type="radio"/> Frequent Urination</p>
<p><input type="radio"/> <input type="radio"/> Smoking/Use Tobacco Products</p> <p><input type="radio"/> <input type="radio"/> Drug/Alcohol Dependence</p>
<p><input type="radio"/> <input type="radio"/> Allergies</p> <p><input type="radio"/> <input type="radio"/> Depression</p> <p><input type="radio"/> <input type="radio"/> Systemic Lupus</p> <p><input type="radio"/> <input type="radio"/> Epilepsy</p> <p><input type="radio"/> <input type="radio"/> Dermatitis/Eczema/Rash</p> <p><input type="radio"/> <input type="radio"/> HIV/AIDS</p>
<p>Females Only</p> <p><input type="radio"/> <input type="radio"/> Birth Control Pills</p> <p><input type="radio"/> <input type="radio"/> Hormonal Replacement</p> <p><input type="radio"/> <input type="radio"/> Pregnancy</p> <p><input type="radio"/> <input type="radio"/></p>
<p>Other Health Problems/Issues</p> <p><input type="radio"/> <input type="radio"/></p> <p><input type="radio"/> <input type="radio"/></p> <p><input type="radio"/> <input type="radio"/></p> |
|---|--|--|

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** _____