WELCOME

ABOUT YOU: Today's Date: _____

Name: _____ How did you hear about us? _____

o **Male** o **Female** **Date of Birth** ____/____/____ Age_____ Height_____ Weight_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Patient SSN:** __ __ __ - __ __ - __ __ __ __

Home Address: _____
Street Address/P.O. Box City State Zip Code

Email address: _____
Employed: ☐ Fulltime ☐ Part Time Job Satisfaction: ☐ Unsatisfied ☐ Satisfied ☐ Very Satisfied
Work Status: ☐ working without restrictions ☐ working with restrictions ☐ not working/off since _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

What type of injury are we seeing you for?
☐ Auto ☐ Other
☐ Work ☐ Sports Injury

EMERGENCY CONTACT INFORMATION:
Emergency Contact Person: _____
Phone #: _____ Relationship: _____

INSURANCE INFORMATION:
☐ I will be paying for the services myself.
☐ Please bill: ☐ Auto Insurance ☐ Worker's Compensation
☐ Health Insurance ☐ Other _____

Insurance Company Name: _____ Adjuster's Name: _____

Insurance Company Address: _____

Insurance ID # or Claim #: _____ Group #: _____

Insurance Company Phone #: _____ Subscriber's Name: _____

Subscriber's Address: _____ Relationship: _____ Subscriber's Date of Birth: ____/__/____

Name of Attorney: _____ Telephone #: _____ Date Retained: _____

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from Dr. Wright. The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand that I have a responsibility to communicate honestly with Dr. Wright and to notify him of any changes in my health status. If an auto injury has been established, I will notify all responsible auto insurance companies of treatment and agree that I will not settle the claim until I have been fully released from Dr. Wright's care.
Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Arizona Sun Chiropractic & Rehab. Any overpayment will be promptly refunded. I also authorize to release any protected health information required to secure payment. Accounts over 90 days delinquent may be subject to a monthly finance charge of 1.5%, 18% annually.
Release of Records: I authorize Dr. Wright to release all health records necessary for my treatment and/or evaluation.

Patient's Signature: _____ Date: ___/__/___

Responsible Party's Signature (if patient is a minor): _____ Date: ___/__/___

Arizona Sun Chiropractic & Rehab. 633 E Ray Road, Suite 110 Gilbert, AZ 85296

Patient Health Questionnaire – PHQ

Patient Name _____ Date _____

1. Describe your symptoms areas. 1:_____ 2:_____

3:_____ 4:_____

5:_____ 6:_____

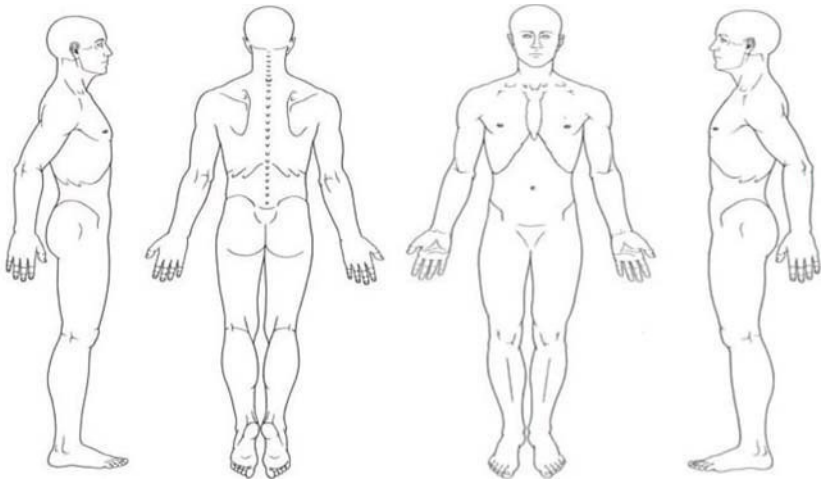
a. When did your symptoms start? _____

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)

Shade the area of where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ○ Sharp ○ Dull
- ○ Ache ○ Numbness
- ○ Shooting ○ Tingling

4. Do symptoms worsen with any of the following?

- ○ Shopping ○ Sleeping
- ○ Housework ○ Reaching
- ○ Driving ○ Lifting: _____lbs.
- ○ Walking ○ Laying Down
- ○ Sitting to Rise ○ Bending Forward
- ○ Standing ○ Bending Backwards
- ○ Social Activities ○ Looking: (up) (down) (Right) (Left)
- ○ Concentration ○ Computers
- ○ Texting ○ Other_____

5. Pain / Discomfort level : **None** **Unbearable**
Circle /Indicate the average intensity of your symptoms (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

6. In general would you say your overall health right now is? ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

_____

7. Who have you seen for your symptoms? ○ No One ○ Chiropractor ○ Medical Doc ○ Physical Therapist ○ Other

a. What treatment did you receive and when?_____

8. 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 (When_____) ○ No

10. What is your occupation? _____

Patient Signature _____ Date _____

Past Medical History

Arizona Sun Chiropractic & Rehab
Dr. Brian Wright
633 E. Ray Rd. Suite 110
Gilbert, AZ 85296

Patient Name: _____ Today's Date: _____

Do you currently or have you had: Please mark all that apply

	Current	Past		Current	Past
Pregnant weeks ____	O	O	Headaches	O	O
Unexplained weight loss	O	O	Muscle weakness	O	O
Unusual fatigue	O	O	Memory loss	O	O
Dizziness or poor balance	O	O	Severe trauma	O	O
Vomited blood	O	O	Direct head trauma	O	O
Bloody or black stools	O	O	Loss of consciousness	O	O
Change in appetite	O	O	Poor coordination	O	O
Fevers	O	O	Night pain that wakes you up	O	O
Night sweats	O	O	Pacemaker	O	O
High blood pressure	O	O	Recent infection	O	O
Chest pain	O	O	History of osteoporosis	O	O
Shortness of breath	O	O	History of cancer	O	O
Chronic cough	O	O	Difficulty breathing	O	O
Stroke	O	O	Use of corticosteroids	O	O
Heart disease or murmur	O	O	Use of anticoagulants	O	O
Loss of bowel or bladder control	O	O	Bleeding or bruising tendency	O	O
More frequent urination	O	O	Numbness in groin	O	O
Pain or blood with urination	O	O	Thyroid trouble	O	O
Infection	O	O	Prolonged use of corticosteroids	O	O
Urinating at night	O	O	Passing out	O	O
Kidney or bladder infection	O	O	Seizures	O	O
Kidney stones	O	O	Diarrhea or constipation	O	O
Recurrent abdominal pain	O	O	Arthritis or gout	O	O
Ulcers	O	O	Diabetes	O	O
Hernia	O	O	High cholesterol	O	O
Sleep problems	O	O	Anemia	O	O

Ever been hospitalized? (Y / N)
Details:_____
_____

Ever been in a MVA? (Y / N)
Details:_____

Does your Mother=M, Father=F, Brother=B, or Sister=S, have any of the following?
Heart Disease:M F B S _____ High Blood Pressure: M F B S _____
Cancer: M F B S_____ Diabetes: M F B S _____
Tuberculosis: M F B S _____ Stroke: M F B S _____
Kidney Disease: M F B S _____ Other: M F B S _____

Arizona Sun Chiropractic & Rehab.

Protocol for Preservation of Patient Records

Pursuant to ARS § 32-3210 and the requirements of the State of Arizona for the Preservation of patient records, this document is intended to inform all patients of Dr. Wright D.C. of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. Dr. Wright D.C agrees to comply with Arizona law for the production of these records and will timely respond to any unreasonable requests.

Dr. Wright D.C will maintain your records for a period of seven years following your last date of service. After seven years from the last date of service, Dr. Wright D.C. reserves the right to destroy your records. Should Dr. Wright D.C. exercise that right, Dr. Wright D.C. will first attempt to contact you and inform you of your right to obtain a copy of these records. Dr. Wright D.C. will attempt to contact you by regular mail, at your last known address, and will give you thirty days to request that your records not be destroyed. If you do not respond to this notice, you will be waving your rights to have your records preserved.

Should Dr. Wright D.C. retire, cease to practice, or sell his practice to another health care professional, Dr. Wright D.C. will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient's last known address.

I, _____, Patient of Dr. Wright D.C., do hereby acknowledge I have read and understood the doctor's protocol for the preservation of patient records. I agree to inform Dr. Wright D.C.'s office of any address changes and acknowledge that all request for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statuary notification requirements to me by regular mail to my indicated address. I understand that failure to complete all of the required fields will be waving my rights to have my records preserved.

Patient Signature:

_____

Responsible Party Signature if Patient is a minor:

_____

Mailing Address:

_____

_____

_____

_____/_____/_____

Date

Dr. Brian Wright
633 E. Ray Rd. Suite 110
Gilbert, AZ 85296
Phone #: (480)222-6059

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Brian Wright, D.C.

633 E. Ray Road, Suite 110
Gilbert, AZ 85296

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your **Notice of Privacy** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy** from time to time and that I may contact this organization any time at the address above for a current copy of the **Notice of Privacy.**

I understand that if there is any information that I chose not disclose on the intake forms, to the doctor, or intentionally did not share, this facility is not liable for any treatments that were given that are contraindications to the information that I chose not to disclose.

I understand that I may request in writing restrictions as to how my private information is used or disclosed to carry out treatment, and payment of health care operations. I also understand that I am not required to agree to my requested restrictions, but if I do agree, then I am bound to abide by such restrictions.

Patient Name:_____

Responsible party signature if patient is a minor:_____

Patient Signature:_____

Date:_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	**Initials**	**Reason**