



Patient Update Form

Please write your legal name on all paperwork

Date_____

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip Code_____

Home Phone _____ Work Phone _____

Cell Phone _____ Email_____

Patient Signature _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

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

Patient Name _____ Date _____

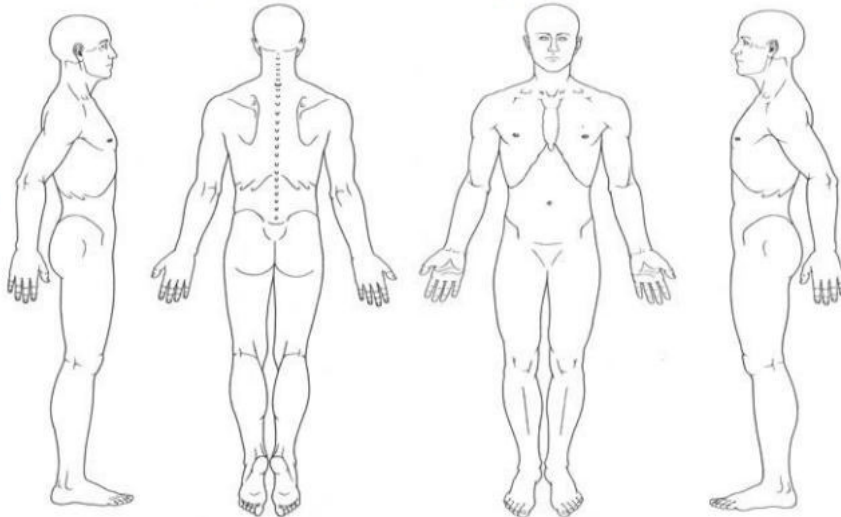
1. Describe your symptoms

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? 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

Average pain intensity:

Last 24 hours: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain
Past week: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

5. How much have your symptoms interfered with your usual daily activities? (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. How is your condition changing, since care began at *this* facility?

- ① N/A — This is the initial visit ② Much worse ③ Worse ④ A little worse ⑤ No change ⑥ A little better ⑦ Better ⑧ Much better

7. In general, would you say your overall health right now is...

- ① Excellent ② Very good ③ Good ④ Fair ⑤ Poor

8. 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
- ② Other Chiropractor

- ③ Medical Doctor ⑤ Other
- ④ Physical Therapist

9. What is your occupation?

- ① Professional/Executive ④ Laborer ⑦ Retired
- ② White Collar/Secretarial ⑤ Homemaker ⑧ Other
- ③ Tradesperson ⑥ FT Student

Patient Signature _____ Date _____

Turn Over ➔

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

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

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

Females Only
☐ Birth Control Pills
☐ Hormonal Replacement
☐ Pregnancy
☐

Other Health Problems/Issues
☐ ☐
☐ ☐
☐ ☐

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 _____

Missed Appointments and Late Cancellation Policy

Thank you for choosing Greenapple Sports and Wellness for your chiropractic care. Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. In order to provide the highest quality services to our patients, we have enforced a Missed Appointment Policy. We understand there are times when you must miss a medical appointment due to emergencies. However, missed appointments impact the flow of patients in our clinics.

Please review the following agreement and sign at the signature line, indicating that you understand our policy.

Our no-show and cancellation policy applies to missed appointments, which include:

- **No-show: You don't arrive for your appointment, and you don't reach out to cancel.**
- **Late cancellation: You cancel your appointment less than 24 hours before your appointment time.**
- **Late reschedule: You reschedule your appointment less than 24 hours before your appointment time.**

You will be subject to a **\$60.00** charge for any missed or cancellations not within the 24 hour period.

You can help us ensure all patients have the appointment access they need by:

- Arriving on time for your appointments.
- Understanding that if you arrive 15 or more minutes after your appointment time, we may need to reschedule your appointment.
- Notifying the clinic at least 24 hours in advance if you cannot make it to your appointment.

Missed appointments due to unforeseen emergency situations, such as medical emergencies or illness, **may** be considered an exception to the policy and will be at the discretion of the practice manager on a case-by-case basis.

As a patient or guardian for a patient receiving services from Greenapple Sports and Wellness, I understand and agree with the following:

Patient Name _____

Patient/Guardian Signature _____

Date _____

CHIROPRACTIC TREATMENT AND ITS RISKS

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing and X-rays. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by hand-guided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, traction, hot and cold packs, hydrotherapy, infrared heat, exercise and nutritional supplements.

Risks of Chiropractic Treatment

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million.

As for chiropractic therapies other than spinal manipulation, the risks are also very slight but can include skin irritation or burns. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

Treatment Options Other Than Chiropractic

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated.

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

Unusual Risks

If your pre-treatment examination reveals any health issues that would make some forms of chiropractic treatment inadvisable (contra-indicated), your chiropractor will explain the risks to you and answer any questions you may have.

Patient Name: _____

Patient Signature: _____

Dr. Signature: _____

Date: _____

DRY NEEDLING CONSENT TO TREAT FORM

Dry Needling (DN) involves inserting a tiny monofilament needle into symptomatic tissue with the intent to reduce pain, increase circulation and improve function of the neuromusculoskeletal system. DN is not traditional Chinese Acupuncture, but instead is based on neurology, physiology and western medical principles. DN is a valuable treatment for musculoskeletal pain; however, like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and/or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:



- Are you taking blood thinners? Yes / No
- Are you or is there a chance you could be pregnant? Yes / No
- Are you aware of any problems or have any concerns with your immune system? Yes / No
- Do you have any known disease or infection that can be transmitted through bodily fluids? Yes / No

Patient's Consent:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I, _____ authorize the performance of Dry Needling.
(print name)

Patient Signature

Date

Relationship to patient (if other than patient)

Date

I was offered a copy of this and refused.

***Dry needling is a non-covered service.
Treatments are \$50.00 per visit.**