CA ACUPUNCTURE & CHIROPRACTIC CLINIC

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that 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 health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

Staff signature **Date**

CA Acupuncture & Chiropractic Clinic

PATIENT HEALTH QUESTIONNAIRE

(Pain Condition Only)

Patient Name: _____ **Date:** _____

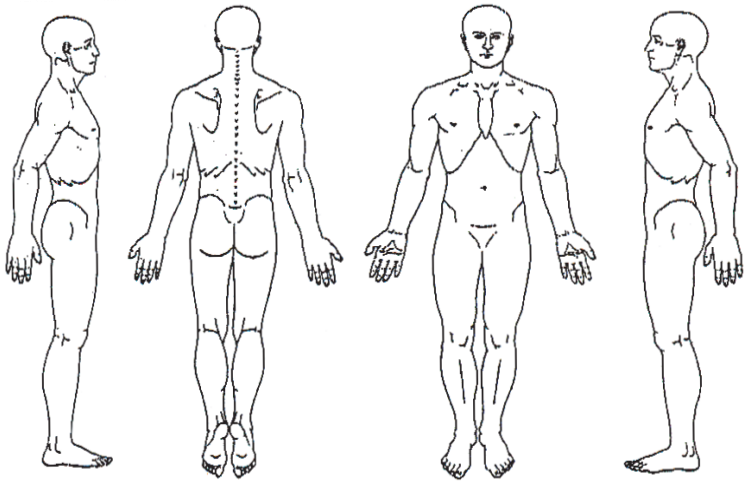
1. Describe your symptoms _____

   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

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)

   Not at all A little bit Moderately Quite a bit Extremely

6. During the past 4 weeks, how much of the time has your condition interfered with your social activities?

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

   a. What treatment did you receive and when? _____

   b. What tests have you had for your symptoms and when were they performed?

   ① X-Rays 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 Other Chiropractor ④ Physical Therapist

10. 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

Treatment Goals: _____