

Corcoran Hamel Chiropractic, PA  
James P. Seim, DC, DACBN  
Diplomate American Board of Clinical Nutrition  
20010 75<sup>th</sup> Ave N.  
Corcoran MN 55340  
763-416-4878

Welcome to Corcoran Hamel Chiropractic, PA. Please fill out this form as completely as possible. This information is confidential and will be treated in accordance with Federal Regulations. Thank You

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse \_\_\_\_\_

Who is responsible for your account? \_\_\_\_\_

Whom may I thank for referring you to my office? \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Policy \_\_\_\_\_ Group \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

**Please provide copies of your Insurance Card**

Why are you seeking care today? \_\_\_\_\_

When did this start? \_\_\_\_\_ Is it due to Illness? \_\_\_\_\_ Injury? \_\_\_\_\_ Wellness Care? \_\_\_\_\_

Did it happen at work? \_\_\_\_\_ Car Accident? \_\_\_\_\_ Other? \_\_\_\_\_

How and where did this happen? \_\_\_\_\_

**Consent for Treatment**

I hereby authorize Dr. Jim Seim and whomever he may designate as his assistance to provide treatment. I understand that there has been no representation as to the results that may be obtained. Further I understand that my insurance is a contract between myself and my insurer and that I am or the Responsible Party is liable for any and all charges incurred.

\_\_\_\_\_ Initial

**Patient Acknowledgement Form -- Receipt of Privacy Practice Statement**

I acknowledge that I have been given the Notice of Privacy Practices for Corcoran Hamel Chiropractic, PA and have had the opportunity to review it.

\_\_\_\_\_ Initial

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Today's Date

Please complete the Authorization and Assignment on the back

# Corcoran Hamel Chiropractic Clinic, PA

James P. Seim, DC, DACBN  
20010 75<sup>th</sup> Avenue North  
Corcoran, MN 55340  
763-416-4878

## Assignment of Insurance Proceeds

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, diagnostic testing, X-Ray interpretation or any other reimbursable treatment or evaluations you receive to our clinic directly.

In exchange for services and supplies rendered, I do assign to Corcoran Hamel Chiropractic, P.A. any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claim awards up the amount of any unpaid balance on my account, In giving this assignment, I acknowledge that I am responsible for all charges to my account.

Initials \_\_\_\_\_

## Records Release Authorization

To: Corcoran Hamel Chiropractic, P.A.

You are authorized to release any information contained in my file to any insurance company, attorney, adjuster, your office staff, including any contracted billing services representing Corcoran Hamel Chiropractic, P.A. in order to process any claim for reimbursement of charges rendered to me by you. I further authorize phone contact with the above listed third parties should phone contact be required for the purpose of obtaining payment for charges outstanding.

Initials \_\_\_\_\_

I have read and agree with the clinic's policy regarding Assignment of Insurance and Release of Records.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

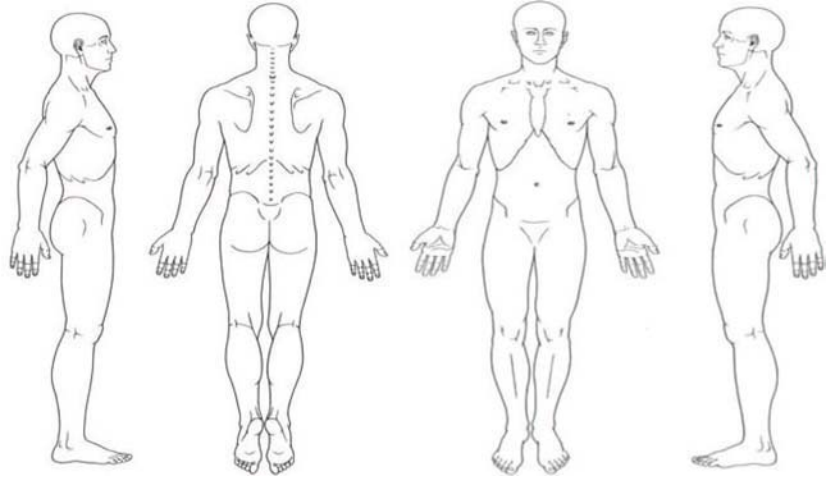
\_\_\_\_\_

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
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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 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)

① Not at all      ② A little bit      ③ Moderately      ④ Quite a bit      ⑤ Extremely

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

(like visiting with friends, relatives, etc)

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

a. What treatment did you receive and when?

\_\_\_\_\_

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

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan 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
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

## 10. What is your occupation?

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

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_