Badger Health Center • S31 W24757 Sunset Drive • Waukesha, WI 53189 • (262) 547-2250

PATIENT HEALTH QUESTIONAIRE

Date:_____

Patient Name:_____

Address: _____

City: _____ Zip: _____

DOB:_____ SSN:_____

Marital Status: Single Married Divorced Widowed

Telephone #: (_____)_____-_____

Cell Phone #: (_____)_____-_____

Email: _____

Employer:_____ Work #: (____)_____-_____

Referred By:_____

Describe your symptoms:	
When did your symptoms start?	
How did your symptoms start?	

Please check the following:

How often do you experience your symptoms?

- ☐ 1 Constantly (76-100% of day)
- ☐ 2 Frequently (51-75% of day)
- ☐ 3 Occasionally (26-50% of day)
- ☐ 4 Intermittently (0-25% of day)

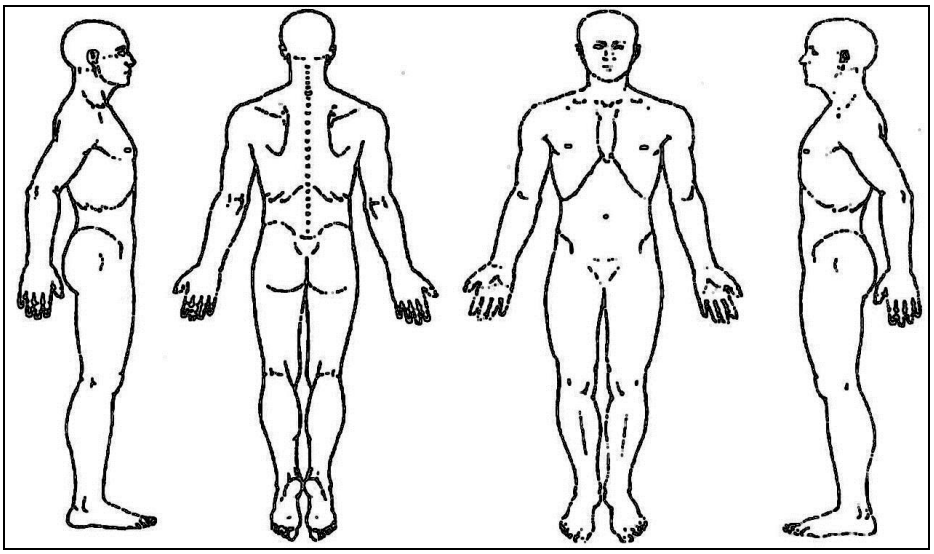
What describes your symptoms?

- ☐ 1 Sharp
- ☐ 2 Dull Ache
- ☐ 3 Numb
- ☐ 4 Shooting
- ☐ 5 Burning
- ☐ 6 Tingling

How are your symptoms changing?

- ☐ 1 Getting Better
- ☐ 2 Not Changing
- ☐ 3 Getting Worse

Indicate where you have pain or other symptoms below:



Regarding your condition:

Circle the average intensity of your symptoms:

None										Unbearable
0	1	2	3	4	5	6	7	8	9	10

Circle how much has pain interfered with your normal work (include both inside and out of home):

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

Have you had similar symptoms in the past? _____ Yes _____ No

If yes, who did you see? ___ No One ___ Chiropractor ___ Other Doctor ___ Other

What tests have you had for your symptoms?

___ X-rays	date	_____	___CT Scan	date	_____
___ MRI	date	_____	___Other	date	_____

Patient Signature (or parent signature if under 18): _____

Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(FEDERAL HIPPA ACT)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

HIPAA regulations effective April 14, 2003 require your medical providers to share their written privacy practices with patients. Please understand that the privacy of your medical records has always been and will continue to be a priority to us. Below is a summary of how we will handle your medical information.

We can use your protected health information or "PHI" for the following purposes without your written consent or authorization.

· Treatment, payment, or healthcare operations
· When required or permitted to do so by federal, state, or local law
· When permitted to do so for matters of public health
· When required for law enforcement or judicial administrative proceedings
· When required to be given to a coroner or medical examiner
· When, consistent with applicable laws, the release is necessary to prevent or lessen threat to public health or safety
· When necessary to comply with worker's compensation requirements
· For organ or tissue donation
· For those involved in the payment of your care

Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information. You have the right to inspect and request a copy of your medical records. You have the right to request restrictions on certain uses and disclosures of your records. These requests must be in writing and we are not required to agree to your requests, but we will respond to any request in writing. If we agree to your written request, that agreement is binding on our part. You have the right to revoke authorization you have given at any time. Again, this must be done in writing. You also have the right to ask for a record of your health information disclosures.

I have been provided with a copy of Badger Health Center's Privacy Practices. I have read and understand these practices and my rights.

Patient/Policyholder Signature: _____ Date: _____

Patient/Policyholder Name (Print): _____

Guardian's name (If patient is under 18 years of age): _____