COOSA VALLEY CHIROPRACTIC CENTER, INC.
DR. SCOTT V. ZYLSTRA
11 S. WESTERN AVE
SYLACAUGA, AL 35150
PHONE 256-245-0404 AND FAX

_____ DATE_____

CONFIDENTIAL PATIENT INFORMATION

NAME_____ _____**SOCIAL SECURITY**_____-_____-____

PHONE: AREA CODE_____ -_____-_____CELL:____-_____-_____

AGE_____DATE OF BIRTH_____-_____-_____ MARITAL STATUS: S M W D

ADDRESS_____CITY_____ST_____ ZIP_____

OCCUPATION_____ EMPLOYER_____

ADDRESS_____ OFFICE PHONE_____

CHILDREN: YES _____ NO _____

NAME OF SPOUSE_____SPOUSE EMPLOYER_____

SPOUSE DATE OF BIRTH_____

(IF MINOR- PARENT NAME AND DATE FOR INSURANCE)

NEAREST RELATIVE NAME **NOT** LIVING WITH YOU:_____
RELATION TO YOU_____ PHONE NO_____

WHERE ARE YOU HURTING TODAY/PRIMARY PROBLEM AREA (REASON FOR VISIT)
_____

WHAT KIND OF PAIN: SHARP, DULL, BURNING, ETC._____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

REFERRED BY:_____ _____ **OR PHONE BOOK**:_____

IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF EMPLOYMENT?____

IS THE CONDITION DUE TO INJURY FROM AUTO ACCIDENT OR OTHER ACCIDENT?_____

DAYS LOST FROM WORK_____ **DATE SYMPTOM APPEARED**_____**OR ACCIDENT HAPPENED**_____
HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? YES____ NO___

IF YES, DESCRIBE:_____

HAVE YOU BEEN TREATED BY A PHYSICIAN IN THE LAST YEAR: YES____ NO___

DESCRIBE:_____

_____

_____

HAVE YOU HAD ANY STERIOD INJECTIONS: WHEN:_____

_____

DO YOU HAVE HEALTH INSURANCE? YES____ NO___

PRIMARY:
NAME OF INSURANCE_____

POLICY HOLDER NAME_____

DATE OF BIRTH:_____- _____-_____ EMPLOYER:_____

POLICY NUMBER:_____**GROUP**_____

SECONDARY INSURANCE:_____

POLICY HOLDERS NAME:_____DATE OF BIRTH:_____

EMPLOYER:_____

POLICY NUMBER:_____ **GROUP** _____

ARE YOU UNDER HOSPICE FOR AN ILLNESS? YES_____ NO_____
Date of Diagnosis:_____
Diagnosis:_____
Hospice Clinic:_____

FEMALE: ARE YOU PREGNANT OR FEEL THERE IS A POSSIBILITY THAT YOU MIGHT BE? : YES_____ NO_____

DATE OF LAST MENSTRUAL PERIOD:_____

DO YOU HAVE A PACEMAKER?_____

DO YOU HAVE A NEUROSTIMULATOR IMPLANT?_____YES____NO ___

DO YOU HAVE ANEURYSM CLIPS?_____YES_____NO

DO YOU HAVE BREAST IMPLANTS?_____YES _____NO

AGREEMENT TO PAY:

I, THE UNDERSIGNED, ACCEPTS THE FEE CHARGED AS A LEGAL AND LAWFUL DEBT AND PROMISES TO PAY SAID FEE, INCLUDING ANY/ALL COLLECTION AGENCY FEES, (33.33%) ATTORNEY FEES, AND COURT COST IF SUCH BE NECESSARY, WAIVING NOW AND FOREVER THE RIGHT TO CLAIM EXEMPTION UNDER THE CONSTITUTION AND LAWS OF THE STATE OF ALABAMA, OR ANY OTHER STATE.

You agree, in order for us to service your account or to collect monies you may owe, Coosa Valley Chiropractic, Inc. my contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Coosa Valley Chiropractic, Inc., its employees and/or agents may contact me /us as described above.

I UNDERSTAND AND AGREE THAT ALL THE INFORMATION ABOVE IS TRUE.
I UNDERSTAND I AM RESPONSIBLE FOR ALL CO-PAYS OR DEDUCTIBLES.
IF I TERMINATE OR SUSPEND MY SCHEDUAL OF CARE AS DETERMINED BY MY TREATING PHYSICIAN, I UNDERSTAND ALL FEES FOR PROFESSIONAL SERVICES WILL BE IMMEDIATELY DUE AND PAYABLE.

SIGNED:_____
Responsible Party Signature

DATE:_____

PARENT SIGNATURE OF MINOR PATIENT:_____

- **PRIVACY NOTICE AVAILABLE UPON REQUEST**
- **Denied:_____**

COOSA VALLEY CHIROPRACTIC CENTER, INC. 256-245-0404

Patient Health Questionnaire - PHQ

Patient Name _____ Date _____

1. Describe your symptoms _____

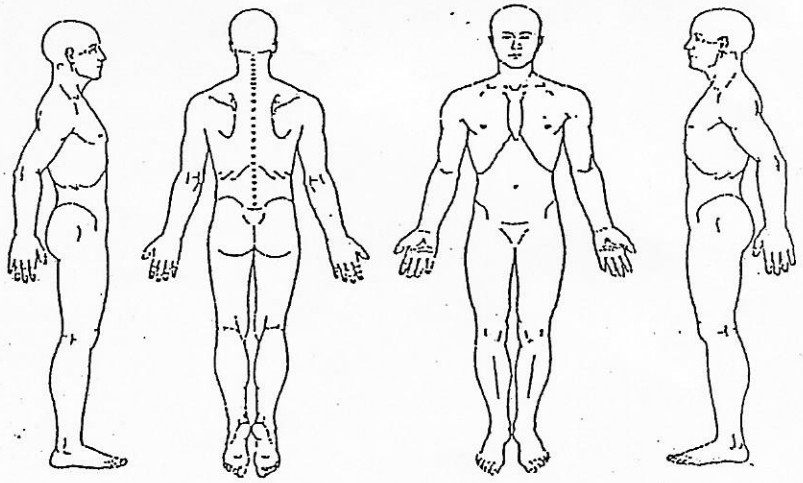
_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?
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)

Indicate where you have pain or other symptom :



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

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: _____ 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

Patient Signature _____ Date _____