CONFIDENTIAL PATIENT HEALTH RECORDS

Dr. Anthony W. Hamm, P.A.
1100 Parkway Dr., Suite B
Goldsboro, NC 27534
(919) 751-1155

PLEASE PRINT AN ANSWER FOR EACH QUESTION

TODAY'S DATE: _____

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

STREET: _____ **CITY&ZIP:** _____

MARITAL STATUS: S M W D # OF CHILDREN: _____

HOME PHONE: _____ **WORK PHONE:** _____

CELL PHONE: _____ **EMAIL:** _____

EMPLOYER: _____ **OCCUPATION:** _____

SPOUSE: _____ **SPOUSE'S EMPLOYER:** _____

PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU TO OUR OFFICE? _____

PLEASE READ OUR OFFICE POLICIES CAREFULLY AND SIGN BELOW

Many of our patients plan to file insurance benefits for the care they receive in our office. Please present your applicable insurance information. We will check with the company to determine you eligibility and benefits. All deductibles, co-pays and/ or co-insurance is expected to be paid at the time of service.

Under NC State General Statute for Returned Checks, it is understood that this office reserves the right to collect a processing fee of $25.00 per returned check.

I, _____, understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I agree that in the event payment in full is not made on or before 30 days after receiving services, I shall be obligated to pay collection expenses which may include but not be limited to court costs, collection agency fees, and attorney's fees of any unpaid balance. I further agree that all collection fees as mentioned herein shall not be deemed to be in the nature of penalty for default, but instead shall be deemed to be liquidated damages.

SIGNATURE: _____ **DATE:** _____

PATIENT HEALTH QUESTIONNAIRE

Dr. Anthony W. Hamm, P.A.
1100 Parkway Dr., Suite B
Goldsboro, NC 27534
(919) 751-1155

Please print or circle an answer for each question.

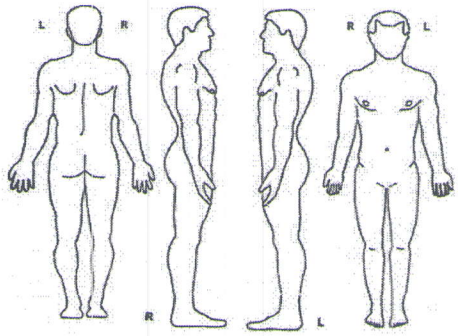
Patient Name: _____ **Date:** _____

Describe the reason for your visit: _____

When did your problem start? _____

How did your problem begin? _____

Indicate on the picture to the right where you have pain or symptoms:



How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What describes the nature of your symptoms?

Sharp Shooting Dull ache Burning Numb Tingling

How are your symptoms changing? Getting Better Not changing Getting Worse

On the pain scale below, indicate your current pain level:

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

How much has your pain interfered with your work or social activities?

Not at all A little bit Moderately Quite a bit All of the time

Have you had similar symptoms in the past? NO YES

Who have you seen about your symptoms?

No One Family Doctor Chiropractor Physical Therapist Other

In general, would you say your overall health is…

Excellent Very Good Good Fair Poor

PATIENT HEALTH QUESTIONNAIRE-PAGE 2

What type of regular exercise do you perform? None Light Moderate Strenuous

What is your current smoking status? Never Smoked Former Smoker Current Smoker

What is your current: Height-_____ **Weight-**_____

List all Medications you are taking (including prescription, OTC, & supplements):

_____

_____

_____

Are you allergic to any medications? Yes No **List:** _____

List all Surgeries and times you have been hospitalized:

_____

_____

_____

Indicate below if you have had any of the conditions listed in the past or currently have them.

	Past	Now		Past	Now		Past	Now
Headaches			High Blood Pressure			Diabetes		
Neck Pain			Heart Attack			Excessive Thirst		
Upper Back Pain			Chest Pains			Frequent Urination		
Mid-Back Pain			Stroke			Drug / Alcohol Dependence		
Low Back Pain			Kidney Stones			Seasonal Allergies		
Shoulder Pain			Bladder Infection			Systemic Lupus		
Upper Arm Pain			Painful Urination			Epilepsy		
Elbow Pain			Loss of Bladder Control			Dermatitis / Eczema / Rash		
Wrist Pain			Prostate Problems			HIV/AIDS		
Hand Pain			Abnormal Weight Gain or Loss			Birth Control Pills		
Hip / Upper Leg Pain			Loss of Appetite			Hormonal Replacement		
Knee / Lower Leg Pain			Abdominal Pain			Pregnancy		
Ankle / Foot Pain			Ulcers			General Fatigue		
Jaw Pain			Hepatitis			Cancer		
Joint Swelling / Stiffness			Muscular Incoordination			Liver / Gall bladder disorder		
Arthritis			Tumor			Asthma		
Rheumatoid Arthritis								

Patient Signature: _____ **Date:** _____