*CELL PHONE # _____

*E-MAIL ADDRESS_____

Patient Health History

Date	I.D. #

Name: _____ Age: _____ Date of Birth: _____ Sex: ☐M ☐F

Address: _____ City: _____ State: ___ Zip: _____

Phone (Home): _____ (Work): _____ Marital Status: ☐S ☐M ☐D ☐W Number of Children: ___

Occupation: _____ Social Security Number: _____

Employer: _____ Driver's License Number: _____

Spouse's Name: _____ Spouse's Age: _____ Spouse's Date of Birth: _____

Spouse's Occupation: _____ Spouse's Social Security Number: _____

Spouse's Employer: _____ Spouse's Phone (Work): _____

Insured's Name: _____ Insured's Phone: _____ Insured's Date of Birth: _____

Insurance Company: _____ Spouse's Insurance Company: _____

How did you hear about this office: _____ Referred by: _____

Past Chiropractic Care: ☐Yes ☐No When? _____ Doctor's Name: _____ Results: _____

Are your present problems due to an injury? ☐Yes ☐No ☐On Job ☐Auto Accident ☐Personal Injury ☐Other: _____

Has the accident been reported? ☐Yes ☐No ☐To Employer ☐Auto Carrier ☐Other: _____

Are you now or have you ever been disabled? (Service or Work)? ☐Yes ☐No When? _____

Have you retained an attorney? ☐Yes ☐No Name & Address: _____

What is your current work status?

☐Full time, no restrictions ☐Full time, restrictions ☐Full time Homemaker ☐Full time student

☐Part time, no restrictions ☐Part time, restrictions ☐Retired ☐Unemployed

☐Off work due to restrictions ☐Other _____

Restrictions:

Off work: ☐Yes ☐No ☐Previously From: _____ to _____

Light duty: ☐Yes ☐No ☐Previously (If yes, what are/were your restrictions?) _____

Do/did you require outside help at home?

☐Yes ☐No (If yes, what help do/did you need?) _____

List any accidents or falls and dates: ☐Auto: _____ ☐Recreation: _____

☐Sports: _____ ☐Work Related: _____ ☐Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ☐Yes ☐No Why? _____

Were you ever knocked unconscious? ☐Yes ☐No (If yes, please explain): _____

Have you ever had X-rays taken? ☐Yes ☐No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you wear orthotics or heal lifts? ☐Yes ☐No Fitted by whom? _____ When? _____

Do you suffer from any condition other than that for which you are now consulting us? ☐Yes ☐No _____

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc?

(Please list) _____

OPERATIONS AND PROCEDURES

☐ I have never had any operations or surgeries

DATE		DATE		DATE	
_____	Vaccinations	_____	Spinal Taps/Injections	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other _____

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ☐Never ☐Previously ☐Presently

Never	Previously	Presently	GENERAL SYMPTOMS
☐	☐	☐	Allergy(What) _____
☐	☐	☐	Bronchitis
☐	☐	☐	Chills (Constant)
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Headache
☐	☐	☐	Loss of Sleep
☐	☐	☐	Loss of Weight
☐	☐	☐	Nervousness
☐	☐	☐	Night Sweats
☐	☐	☐	Numbness or Pain in arms/legs/hands
☐	☐	☐	Wheezing

Never	Previously	Presently	GASTRO-INTESTINAL
☐	☐	☐	Belching or Gas
☐	☐	☐	Colon Trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Gall Bladder Trouble
☐	☐	☐	Hemorrhoids (piles)
☐	☐	☐	Jaundice
☐	☐	☐	Liver Trouble
☐	☐	☐	Nausea
☐	☐	☐	Stomach Pain
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting Blood
☐	☐	☐	Heart Burn
☐	☐	☐	Bloody Stools
☐	☐	☐	Acid Reflux
☐	☐	☐	Irritable Bowel

Never	Previously	Presently	EYE/EAR NOSE/THROAT
☐	☐	☐	Asthma
☐	☐	☐	Deafness
☐	☐	☐	Earache
☐	☐	☐	Ear Discharge
☐	☐	☐	Ear Noises
☐	☐	☐	Thyroid Problems
☐	☐	☐	Frequent Colds
☐	☐	☐	Hay Fever
☐	☐	☐	Nasal Obstruction
☐	☐	☐	Nose Bleeds
☐	☐	☐	Pain in Eyes
☐	☐	☐	Poor Vision
☐	☐	☐	Blurred Vision
☐	☐	☐	Sinusitis
☐	☐	☐	Sore Throats
☐	☐	☐	Tonsillitis

Never	Previously	Presently	RESPIRATORY
☐	☐	☐	Chest Pain
☐	☐	☐	Chronic Cough
☐	☐	☐	Difficulty Breathing
☐	☐	☐	Spitting Blood
☐	☐	☐	Spitting Phlegm

GENITO-URINARY

☐	☐	☐	Bed Wetting
☐	☐	☐	Blood in Urine
☐	☐	☐	Frequent Urination
☐	☐	☐	Inability to Control Urine
☐	☐	☐	Kidney Infection
☐	☐	☐	Kidney Stones
☐	☐	☐	Painful Urination
☐	☐	☐	Prostate Trouble

MUSCLES & JOINTS

☐	☐	☐	Backache
☐	☐	☐	Foot Trouble
☐	☐	☐	Hernia
☐	☐	☐	Pain Between Shoulders
☐	☐	☐	Painful Tail Bone
☐	☐	☐	Stiff Neck
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen Joints
☐	☐	☐	Tremors
☐	☐	☐	Twitching

CARD'O-VASCULAR

☐	☐	☐	High Blood Pressure
☐	☐	☐	Low Blood Pressure
☐	☐	☐	Chest Pain
☐	☐	☐	Heart Trouble
☐	☐	☐	Poor Circulation
☐	☐	☐	Rapid Heart
☐	☐	☐	Slow Heart
☐	☐	☐	Strokes
☐	☐	☐	Swelling Ankles
☐	☐	☐	Varicose Veins

SKIN OR ALLERGIES

☐	☐	☐	Bruising Easily
☐	☐	☐	Dryness
☐	☐	☐	Eczema
☐	☐	☐	Hives or Allergy
☐	☐	☐	Itching
☐	☐	☐	Sensitive Skin
☐	☐	☐	Skin Eruptions

FOR FEMALES ONLY

☐	☐	☐	Cramps
☐	☐	☐	Hot Flashes
☐	☐	☐	Irregular Cycle
☐	☐	☐	Painful Periods
☐	☐	☐	Vaginal Discharge

☐Yes ☐No Pregnant at this Time

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐Appendicitis	☐Anemia	☐Heart Disease	☐Arthritis	☐Pneumonia	☐Measles
☐Goiter	☐Epilepsy	☐Rheumatic Fever	☐Mumps	☐Influenza	☐Mental Disorder
☐Polio	☐Chicken Pox	☐Pleurisy	☐Lumbago	☐Tuberculosis	☐Diabetes
☐Alcoholism	☐Eczema	☐Whooping Cough	☐Cancer	☐Venereal Disease	☐HIV Positive

HABITS

☐Smoking	Packs/day: _____
☐Drinking	Alcohol: (Cups/day) _____
☐Coffee	Cups/Day: _____
☐Soft Drink	Bottles or Cans/Day: _____
☐Water	Cups/Day: _____

EXERCISE

☐None

☐Moderate

☐Daily

Type: _____

_____

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother(s), # of_____	☐	☐	☐	☐
Sister(s), # of _____	☐	☐	☐	☐

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider ***will/will not*** prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. *Describe your symptoms* _____

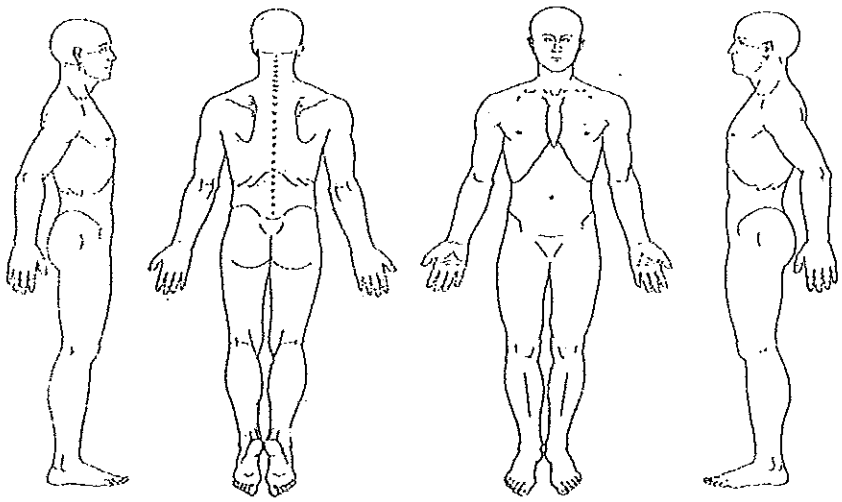
_____

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 symptoms



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 <u>past 4 weeks</u>:*

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 <u>past 4 weeks</u> 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** _____