Patient Present Complaints

Name ____ Date ____________

Address ____________________________ City ____________ State _____ Zip ________

Telephone ____________ Social Security# ______________ Driver Lic.# ____________

Age ________ Birthdate ____ / ____ / ____ Sex M / F ____ Status M S W D _____ No. Children ________

Occupation ______________ Employer ______________________ Years Employed ________

Address ____________________________ City ____________ State _____ Zip ________

Work Phone ______________________ Ext. ________ Referred By: ______________________

Spouse's Name ____________ Occupation ____________ Employer ____________ Soc. Sec.# ____________

Please describe your problem and how it began. ***Date problem began:*** ___ / ___ / ___

____

____

How bad is your pain? (Circle a number)	0 No Pain	1	2	3	4	5	6	7	8	9	10 Unbearable Pain

How often are your symptoms present?	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Intermittently

Describe your <u>current</u> pain/symptoms:	☐ Sharp/Stabbing	☐ Throbbing	☐ Aches
	☐ Dull	☐ Soreness	☐ Weakness
	☐ Numbness	☐ Shooting	☐ Gripping
	☐ Burning	☐ Tingling	☐ Other ________
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change
What makes the problem better?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ Inactivity/rest	☐ Other ________
What makes the problem worse?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ inactivity/rest	☐ Other ________
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting	☐ Light Labor	☐ Heavy Labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High

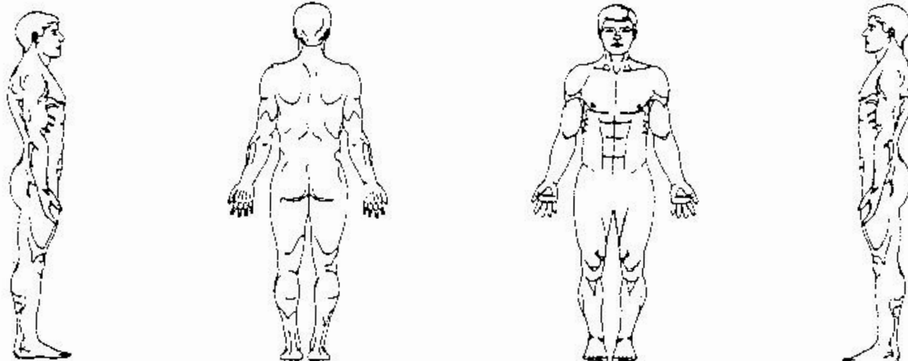
What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

____

Have you had X-rays, MR or other tests for this condition? What tests and When? ____________________

____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: ______________________________________ Date: ____________________

Patient Health Questionnaire

Patient Name________________________________ Patient ID#____________

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R_____ L_____)
☐	☐	Pain in Upper Arm or Elbow (R_____ L_____)
☐	☐	Hand Pain (R_____ L_____
☐	☐	Wrist Pain (R_____ L_____
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R_____ L_____)
☐	☐	Pain in Lower Leg or Knee (R_____ L_____)
☐	☐	Pain in Ankle or Foot (R_____ L_____)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstral Flow
☐	☐	Profuse Menstral Flow
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date)____________
☐	☐	Stroke (date)____________
☐	☐	Asthma
☐	☐	Cancer, Explain____________
☐	☐	Tumor, Explain____________
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver / Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other____________

If a family member has had any of the following, please mark the appropriate box:

☐	Cancer	☐	Epilepsy
☐	Rheumatoid	☐	Chronic Back Problems
☐	Diabetes	☐	Chronic Headaches
☐	Heart Problems	☐	Lupus
☐	Lung Problems	☐	Other ____________
☐	High Blood Pressure____________		

Do you have a permanent disability rating? ☐ **Yes** ☐ **No**

Location____________

Date rating received____________

Rating Percentage____________

Present Weight____________pounds

Height _______feet _______inches

Please check any of the following that apply to you.

Past	Present	
☐	☐	Pregnancy, # births____________
☐	☐	Birth Control Pills, type____________
☐	☐	Medications (list if not listed elsewhere) ____________
☐	☐	Hospitalizations/Surgical Procedures ____________
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffinated Soft drinks: cups/cans per day:____________

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature:________________________ Date: ____________

Patient Billing Information

Patient's Name ______________________________ Date __________

Treating Chiropractor:

Do you have Health Insurance? *Yes* *No*

Insurance Company Name ______________________________

Do you have Chiropractic Benefits on your plan? *Yes* *No* *Uncertain*

Subscriber's Name ______________________________ I.D. # __________

Subscriber's Date of Birth ______________

Subscriber's Employer ______________________________

Relationship to Subscriber: *Self* *Spouse* *Dependent* *Other* __________

I clearly understand and agree that I am responsible for payment of any and all services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Patients with group or individual insurance are responsible for any unpaid balance in the event their insurance either does not cover chiropractic or is terminated during treatment. I, the undersigned, affirm that the above is true and correct, and consent to chiropractic care in this office.

Patient's Signature ______________________________ Date __________
(Guardian Must sign for all patients 17 years old or younger)

(staff use only)

Received copy of Patient's Insurance Card? *Yes* *No* *Staff Init.* __________

Gave A.C.N. Paperwork? *Yes* *No* *Staff Init.* __________

A.C.N. Paperwork Completed? *Yes* *No* *Staff Init.* __________

DIAGNOSIS:

____

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____

PATIENT #______________ **ACCT. DATE**______________

Dr.:

Class: Cash PI WC PPO MC

Referral Type: Pt. RE Staff Fair Other