

PATIENT INFORMATION

Date _____ Chart# _____

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

COUNTY _____ HOME PHONE _____

SOCIAL SECURITY# _____ BIRTH DATE _____ AGE _____ SEX _____

OCCUPATION _____ EMPLOYED BY _____ WORK PHONE _____

WORK ADDRESS _____ CITY/STATE/ZIP _____

#OF CHILDREN _____ MARITAL STATUS S M D W DRIVER'S LICENSE# _____

SPOUSES NAME _____ PERSON RESPONSIBLE FOR PAYMENT _____

PERSON TO CONTACT IN CASE OF EMERGENCY-NAME _____

ADDRESS _____ PHONE# _____

HOW WERE YOU REFERRED TO OUR OFFICE? FRIEND'S NAME _____

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? _____ IF YES, WHEN _____

WHAT IS YOUR MAJOR COMPLAINT? _____

IS THIS CONDITION DUE TO AN: A)AUTO ACCIDENT B)WORK INJURY C)OTHER ACCIDENT
D)UNKNOWN CAUSE E)ILLNESS

Allergies

Medicinal	Other
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications	Recurrent Problems
_____	_____
_____	_____
_____	_____
_____	_____

E-MAIL ADDRESS: _____

PATIENT HISTORY

OPERATIONS

Tonsillectomy _____	Complications _____	Date _____
Appendectomy _____	Complications _____	Date _____
Hernia Repair _____	Complications _____	Date _____
Gallbladder _____	Complications _____	Date _____
Hysterectomy _____	Complications _____	Date _____
Hemorrhoidectomy _____	Complications _____	Date _____
Other _____	Complications _____	Date _____
Radiation therapy _____	Complications _____	Date _____

HOSPITALIZATIONS

	Description	Hospital	Year
Illness (Kind)	_____	_____	_____
Surgery (Kind)	_____	_____	_____
Other (Reason)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

INJURIES/MOTOR VEHICLE ACCIDENTS _____

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance.

Personal Habits

Please answer honestly. This information is needed to assure the best possible treatment. All information is confidential. Please rate your answer on a scale of 1 to 5 (1=No/Never, 5=Yes/Often.)

	1	2	3	4	5	Elaborate
Exercise Regularly (3 to 4 x WK)	1	2	3	4	5	_____
Wear Seat Belts	1	2	3	4	5	_____
Use Drugs	1	2	3	4	5	_____
Drink Alcohol	1	2	3	4	5	_____
Smoke	1	2	3	4	5	_____
Chew Tobacco	1	2	3	4	5	_____
Experience Stress	1	2	3	4	5	_____
Other	1	2	3	4	5	_____

PERSONAL HISTORY

PERSONAL/FAMILY HISTORY		Number of Siblings					
PERSONAL	YES	WHEN	NO	FAMILY	YES	SPECIFIC MEMBER	NO
Abdominal bleeding							
Allergies							
Anemia							
Arthritis							
Asthma/Emphysema							
Back Disorders							
Backache							
Black Tarry Stools							
Bleeding Diseases							
Blood in Stool							
Blood in Urine							
Cancer							
Change in Bowel habits							
Chest Pain							
Colitis							
Constipation							
Convulsion							
Cough							
Coughing Blood							
Depression							
Diabetes							
Diahrea							
Difficulty Swallowing							
Dizziness							
Enlarged Heart							
Double Vision							
Epilepsy							
Fainting Spells							
Gallstones							
Gall Bladder Disorder							
Glaucoma							
Headaches							
Heart Disease							
Heart Murmur							
Hepatitis							
Hoarseness							
High Blood Pressure							
Indigestion							
Irregular Heart Beat							
Kidney Infection							
Kidney Stone							
Leg Pain							
Lung Disease							
Lyme Disease							
Nocturia							
Nosebleeds							
Nervous Disorder							
Painful Urination							
Paralysis							
Phlebitis							
Pleurisy							
Pneumonia							
Pus in Urine							
Rheumatic Fever							
Shortness of Breath							
Stroke							
Swelling of feet							
Swollen/Painful Joints							
T.B.							
Thyroid Disease							
Ulcer							
Venereal Disease							
Vomited Blood							
Other							

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

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

Patient Name _____ Date _____

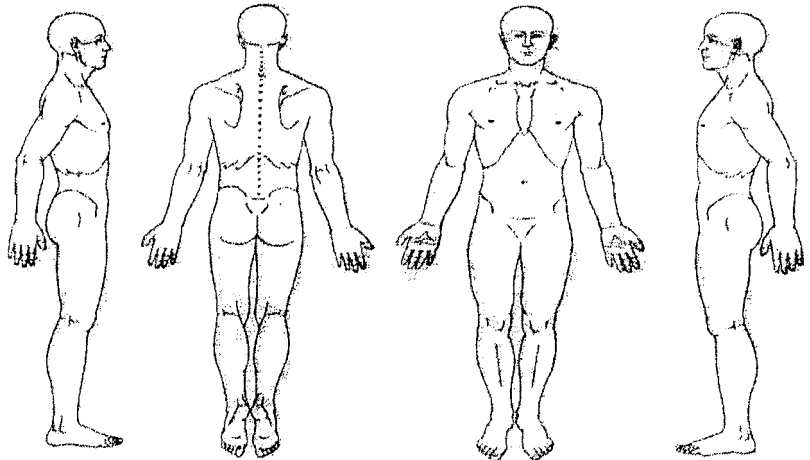
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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 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
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

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: _____
- ② MRI date: _____
- ③ CT Scan 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
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

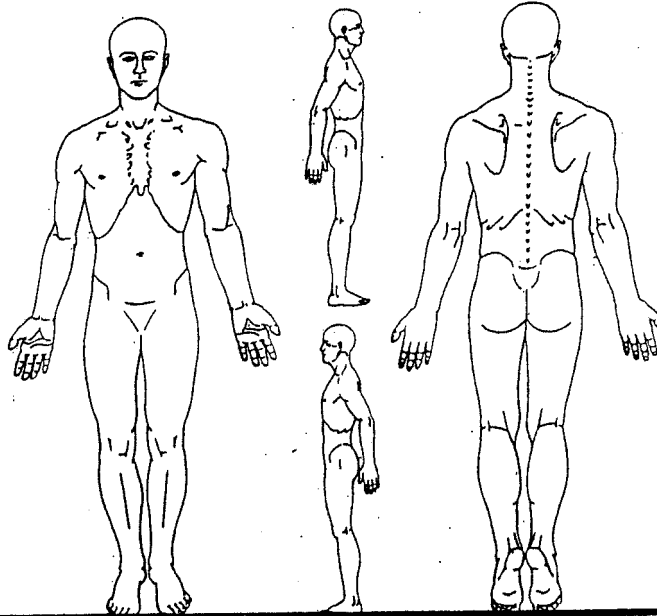
a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS/SENSATIONS RIGHT NOW:

A=ACHE B=BURNING N=NUMBNESS
 P=PINS/NEEDLES S= STABBING O=OTHER



*Indicate the average intensity of your symptoms and how often they occur by using the scale below:

PAIN LEVEL	FREQUENCY (C=Constant F=Frequent I=Intermittent O=Occasional)													
Headaches	No pain	0	1	2	3	4	5	6	7	8	9	10	Extreme pain	C/ F/ I/ O
Neck	No pain	0	1	2	3	4	5	6	7	8	9	10	Extreme pain	C/ F/ I/ O
Mid-Back	No pain	0	1	2	3	4	5	6	7	8	9	10	Extreme pain	C/ F/ I/ O
Low Back	No pain	0	1	2	3	4	5	6	7	8	9	10	Extreme pain	C/ F/ I/ O
U. Extremity (shoulder, elbow, wrist)	No pain	0	1	2	3	4	5	6	7	8	9	10	Extreme pain	C/ F/ I/ O
L. Extremity (hip, knee, foot)	No pain	0	1	2	3	4	5	6	7	8	9	10	Extreme pain	C/ F/ I/ O

Patient Signature _____ Date _____

Acct# _____

PAIN RELIEF CENTER