PATIENT DATA SHEET

GENERAL INFORMATION

___/___/____
DATE

____
LAST NAME **FIRST NAME** **MIDDLE INITIAL**

____
ADDRESS **CITY** **STATE** **ZIP CODE**

( )______________________________ ( )______________________________ ( )______________________________
HOME PHONE **WORK PHONE** **CELL PHONE**

____
EMAIL ADDRESS

SEX MALE FEMALE
(PLEASE CIRCLE)

MARITAL STATUS SINGLE LEGALLY SEPARATED MARRIED WIDOWED DIVORCED
(PLEASE CIRCLE)

____/____/_____ _________-________-________
BIRTHDATE **SOCIAL SECURITY**

____
REFERRED BY (EXAMPLE: DR, FRIEND, ETC – PLEASE NAME)

INSURANCE INFORMATION

PRIMARY POLICY HOLDERS NAME:___________________________________DATE OF BIRTH:______________________

EMPLOYER INFORMATION

WORK STATUS EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT SELF-EMPLOYED
(PLEASE CIRCLE) HOMEMAKER OTHER

____
OCCUPATION/ TYPE OF WORK

____
EMPLOYER

____
EMPLOYER ADDRESS **CITY** **STATE** **ZIP CODE**

____( )______________________________
EMPLOYER CONTACT PERSON **PHONE**

CONDITION INFORMATION

IS YOUR CURRENT COMPLAINT THE DIRECT RESULT OF:
(PLEASE CIRCLE)

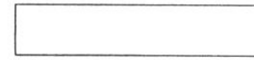
WORK ACCIDENT YES NO _____/_____/_____
AUTO ACCIDENT YES NO ACCIDENT DATE
OTHER? (EXPLAIN) ___________________________________

____

____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202



ACN Group, Inc. Use Only rev 7/18/05

Patient Name ______________________ *Date* ______________________

1. Describe your symptoms ______________________

____

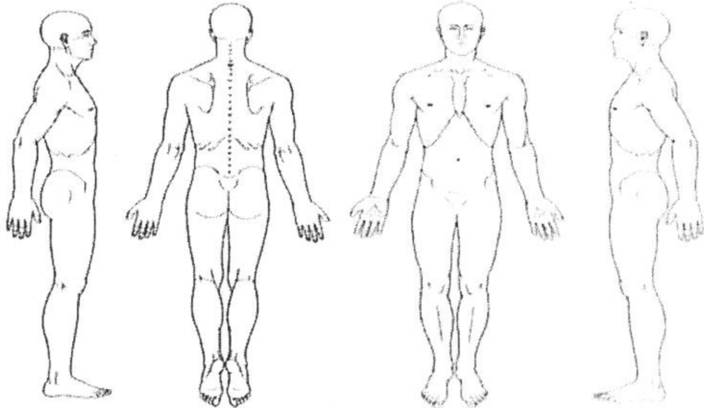
a. When did your symptoms start? ______________________

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 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 ② 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:* __________ 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 ② 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* ______________________

PAST HEALTH FORM

THE FOLLOWING MAY SEEN UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT, HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CHIROPRACTIC CARE.

PLEASE CHECK ALL THAT APPLY
MAJOR SURGERIES/OPERATIONS:

☐ APPENDECTOMY ☐ TONSILLECTOMY ☐ GALL BLADDER ☐ HERNIA ☐ BACK SURGERY
☐ BROKEN BONES ☐ OTHER: ____

MAJOR ACCIDENT OR FALLS (<u>OTHER THAN</u> WHAT YOU ARE BEING SEEN FOR TODAY) ______________________________

____

HOSPITALIZATION (OTHER THAN ABOVE) ____

PLEASE LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING

____

____

DO YOU WEAR A SHOE LIFT? YES NO

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ PNEUMONIA
☐ RHEUMATIC FEVER
☐ POLIO
☐ TUBERCULOSIS
☐ WHOOPING COUGH
☐ ANEMIA
☐ MEASLES
☐ MUMPS
☐ SMALL POX
☐ CHICKEN POX
☐ DIABETES
☐ CANCER
☐ HEART DISEASE
☐ THYROID
☐ INFLUENZA
☐ PLEURISY
☐ ARTHRITIS
☐ EPILEPSY
☐ MENTAL DISORDERS
☐ LUMBAGO
☐ ECZEMA

INTAKE

☐ COFFEE, CUPS/DAY______
☐ TEA CUPS/DAY______
☐ ALCOHOL, DRKS/WK____
☐ CIGARETTES, PK/DAY___
☐ WHITE SUGAR

CHECK ANY OF THE FOLLOWING YOU HAVE HAD <u>REGULARLY</u> THE PAST 6 MONTHS:

MUSCULO-SKELETAL

☐ LOW BACK PAIN
☐ PAIN BETWEEN SHOULDERS
☐ NECK PAIN
☐ ARM PAIN
☐ JOINT PAIN/STIFFNESS
☐ WALKING PROBLEMS
☐ DIFFICULT CHEWING/CLICKING JAW
☐ GENERAL STIFFNESS

NERVOUS SYSTEM

☐ NERVOUSNESS
☐ NUMBNESS
☐ PARALYSIS
☐ DIZZINESS
☐ FORGETFULNESS
☐ CONFUSION/DEPRESSION
☐ FAINTING
☐ CONVULSIONS
☐ COLD/TINGLING EXTREMITIES
☐ STRESS

GENERAL

☐ FATIGUE
☐ ALLERGIES
☐ LOSS OF SLEEP
☐ FEVER
☐ HEADACHES

GASTRO-INTESTINAL

☐ POOR/EXCESSIVE APPETITE
☐ EXCESSIVE THIRST
☐ FREQUENT NAUSEA
☐ VOMITING
☐ DIARRHEA
☐ CONSTIPATION
☐ HEMORRHOIDS
☐ LIVER PROBLEMS
☐ GALL BLADDER PROBLEMS
☐ WEIGHT TROUBLE
☐ ABDOMINAL CRAMPS
☐ GAS/BLOATING AFTER MEALS
☐ HEARTBURN
☐ BLACK/BLOODY STOOL
☐ COLITIS

GENITO-URINARY

☐ BLADDER TROUBLE
☐ PAINFUL/EXCESSIVE URINATION
☐ DISCOLORED URINE

EENT

☐ VISION PROBLEMS
☐ DENTAL PROBLEMS
☐ SORE THROAT
☐ EAR ACHES
☐ HEARING DIFFICULTY
☐ STUFFED NOSE

C-V-R

☐ CHEST PAIN
☐ SHORT BREATH
☐ BLOOD PRESSURE PROBLEMS
☐ IRREGULAR HEARTBEAT
☐ HEART PROBLEMS
☐ LUNG PROBLEMS/CONGESTION
☐ VARICOSE VEINS
☐ ANKLE SWELLING
☐ STROKE

MALE/FEMALE

☐ MENSTRUAL IRREGULARITY
☐ MENSTRUAL CRAMPS
☐ VAGINAL PAIN/INFECTION
☐ BREAST PAIN/LUMPS
☐ PROSTATE/SEXUAL DYSFUNCTION
☐ OTHER PROBLEMS:
☐ ____________________________

FEMALES ONLY:

WHEN WAS YOUR LAST PERIOD? ____________
ARE YOU PREGNANT ☐ YES ☐ NO ☐ NOT SURE

FAMILY HISTORY

THE FOLLOWING MEMBERS HAVE A SAME OR SIMILAR PROBLEM AS I DO:

☐ MOTHER ☐ SISTER
☐ FATHER ☐ SPOUSE
☐ BROTHER ☐ CHILD