PATIENT HISTORY

(PLEASE PRINT) Date: _____

Name: _____ Phone(hm) _____ (cell) _____ (wk) _____

Address, City, State, Zip _____

Birth date _____ Age _____ ◯Male ◯Female Spouse's Name(or Parent) _____

#Children _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed Occupation _____

Employer _____ Address _____

City, State, Zip _____ Social Security # _____

How were you referred to our office _____

Have you ever had Chiropractic Care before? _____ If yes, when? _____

List your chief complaints in order of severity:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

List other Doctors consulted for this condition:

1. _____ Address _____

2. _____ Address _____

Is this injury or illness work related? _____ Have you reported it to your employer? _____

Is this injury or illness related to an automobile accident? _____

Your Auto Insurance Co. _____ Policy # _____ Claim # _____

Address _____ Phone # _____ Agent's Name _____

Do you have any type of Health Insurance? _____ Company _____

Address _____ Policy # _____

Are you covered under any other group or individual health polity through yourself or spouse?

Company _____ Policy # _____ Claim # _____

Address _____ Phone # _____ Agent's Name _____

Spouse's Social Security # _____ Spouse's Birth date _____ Employer _____

Address, City, State, Zip _____

Method of payment you plan to use for today's charges: ☐ Cash ☐ Check ☐ Visa ☐ MasterCard

NOTICE: Not all patient require X-Rays to determine or verify a diagnosis, type and length of care. If your examination warrants X-Rays analysis, the following office policy prevails:
1. All first visit charges are payable when services are rendered.
2. The fee paid for X-Rays is for analysis only. The film itself is the property of this office and cannot be released.

Patient's Signature _____ Date _____

Are you here for a free spinal exam only: ☐ Yes ☐ No

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 _____

_____

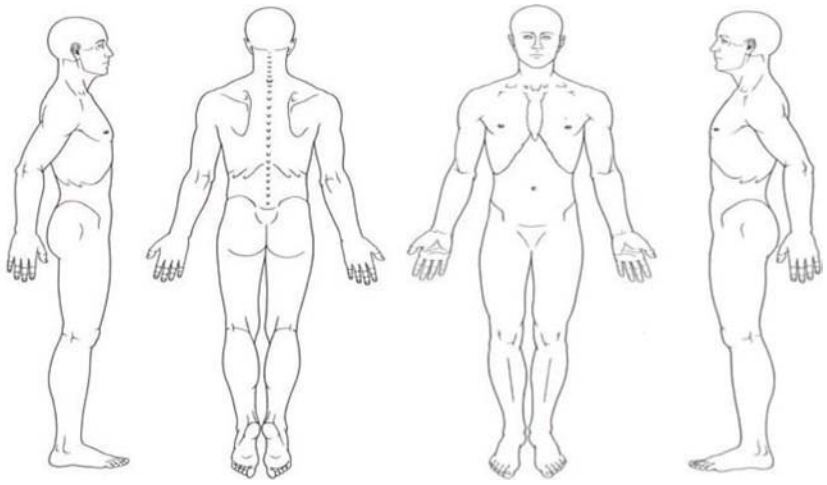
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- ○ Constantly (76-100% of the day)
- ○ Frequently (51-75% of the day)
- ○ Occasionally (26-50% of the day)
- ○ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ○ Sharp ○ Shooting
- ○ Dull ache ○ Burning
- ○ Numb ○ Tingling

4. How are your symptoms changing?

- ○ Getting Better
- ○ Not Changing
- ○ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ 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)

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

7. In general would you say your overall health right now is...

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

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8. Who have you seen for your symptoms?

○ No One ○ Medical Doctor ○ Other
○ Chiropractor ○ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

9. Have you had similar symptoms in the past? ○ Yes ○ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

○ This Office ○ Medical Doctor ○ Other
○ Chiropractor ○ Physical Therapist

10. What is your occupation?

_____

○ Professional/Executive ○ Laborer ○ Retired
○ White Collar/Secretarial ○ Homemaker ○ Other
○ Tradesperson ○ FT Student

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

○ Full-time ○ Self-employed ○ Off work
○ Part-time ○ Unemployed ○ Other

Patient Signature _____ **Date** _____

PASADENA FAMILY CHIROPRACTIC

PATIENT'S PRESENT COMPLAINTS

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
☐	☐	Dullness
☐	☐	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
☐	☐	Anginl
☐	☐	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
☐ Rheumatoid Arthritis
☐ Diabetes
☐ Heart Problems
☐ Lung Problems
☐ High Blood Pressure
☐ Epilepsy
☐ Chronic Back Problems
☐ Chronic Headaches
☐ Lupus
☐ Other _____
_____

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

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 (list if not described elsewhere) _____

Past	Present	
☐	☐	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: _____