PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date ________________ Patient Name ______________________________ Patient # __________

FIRST MI LAST

SS #/SIN ______________ ☐ Male ☐ Female Birthdate ______________ Home phone ____________

Address ____________________ City ______________ State/Prov. ______ Zip/P.C. ________

E-Mail ____________________ Cell Phone ____________________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parent/guardian's employer ____________________ Work phone ____________

Business address ____________________ City ______________ State/Prov. ______ Zip/P.C. ________

Spouse or parent/guardian's name ______________ Employer ____________ Work phone ____________

If patient is a student, name of school/college ____________________ City __________ State/Prov. ______

Whom may we thank for referring you? ________________________________

Person to contact in case of emergency ____________________ Phone ____________

In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X ______________________________ ______________________________

Parent or guardian signature Date

Responsible Party

Name of person responsible for this account ____________________ Relationship to patient ____________

Address ______________________________ Home phone ____________

E-Mail ______________________________ Cell phone ____________

Driver's license # ______________ Birthdate ______________ Financial institution ____________

Employer ______________________________ Work phone ____________

Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Name of insured ______________________________ Relationship to patient ____________

Birthdate ______________ SS #/SIN ____________________ Date employed ____________

Name of employer ____________________ Work phone ____________________

Address of employer ______________ City ______________ State/Prov. ______ Zip/P.C. ________

Insurance company ______________ Group # ______________ Union or local # ____________

Ins. Co. address ______________ City ______________ State/Prov. ______ Zip/P.C. ________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured ______________________________ Relationship to patient ____________

Birthdate ______________ SS #/SIN ____________________ Date employed ____________

Name of employer ____________________ Work phone ____________________

Address of employer ______________ City ______________ State/Prov. ______ Zip/P.C. ________

Insurance company ______________ Group # ______________ Union or local # ____________

Ins. Co. address ______________ City ______________ State/Prov. ______ Zip/P.C. ________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X ______________________________ ______________________________

Signature of patient or parent/guardian if minor Date

Patient Health Questionnaire

American Chiropractic Network

ACN Use Only rev 4/23/99

*Patient Name*____________________ *Date*____________________

1. When did your symptoms start: ________________ **Describe your symptoms and how they began:**

____

____

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
- 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. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse: ____________________

8. What activities make your symptoms better: ____________________

9. Who have you seen for your symptoms?
- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment? ____________________

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:*__________

10. 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

11. 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

12. What do you hope to get from your visit/treatment *(select all that apply)*:
- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

*Patient Signature*____________________ *Date* ____________________

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name ______________________ *Date* ______________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ] [ ] [ ] (Feet, Inches) Weight [ ] [ ] [ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	Condition
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	Condition
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

Past	Present	Condition
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

Past	Present	Condition
○	○	
○	○	
○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ ______________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

______________ ______________ ______________

______________ ______________ ______________

List all the surgical procedures you have had and times you have been hospitalized:

______________ ______________ ______________

______________ ______________ ______________

Patient Signature ______________________ *Date* ______________

Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ *Date* ______________