

PATIENT INFORMATION

Date: _____

Name: _____ Birthdate: _____

Address: _____ City: _____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Please describe the main complaint for which you are seeking treatment:

How does this affect your daily life (can't sleep, care for children, play golf, etc)?

How and when did your symptoms first occur?

Have you seen any other providers for your symptoms, if so who?

Have you had these symptoms before? Yes ___ No ___ If so, when? _____

Do you have any secondary complaints, if so please describe?

Have you ever been to a chiropractor before? Yes ___ No ___

If you have, who did you see? _____ How long ago? _____

Was that for a similar condition? _____

Do you have any specific questions or concerns for the doctor before you begin treatment? _____

If you have insurance please allow us to make a copy of your card and a photo ID for proper billing information.

FEES ARE PAYABLE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC IN YOUR PERMANENT FILE. I HEARBY GIVE MY PERMISSION FOR TREATMENT.

Signature of Patient: _____

Social Security Number: _____

PATIENT HEALTH QUESTIONNAIRE

Name _____ Date _____

If you have ever had a listed symptom in the past, please check that symptom in the past column. If you are presently having a particular symptom, check that symptom in the present column.

Past	Present	Condition	Past	Present	Condition
___	___	Abdominal Pain	___	___	Abnormal Weight Gain/Loss
___	___	Angina	___	___	Anorexia
___	___	Aortic Aneurysm	___	___	Arthritis
___	___	Asthma	___	___	Bladder Infection
___	___	Blood Disorder	___	___	Breast __Soreness __Lumps
___	___	Cancer, Explain _____	___	___	Chronic Cough
___	___	Chest Pain	___	___	Colitis
___	___	Chronic Sinusitis	___	___	Convulsions
___	___	Constipation	___	___	Depression
___	___	Diabetes	___	___	Difficulty in swallowing
___	___	Dermatitis/Eczema/Rash	___	___	Emphysema
___	___	Dizziness	___	___	Epilepsy
___	___	Endometriosis	___	___	Fainting
___	___	Excessive Thirst	___	___	General Fatigue
___	___	Frequent Urination	___	___	Headache
___	___	Hand Pain (R__ L__)	___	___	Heartburn/Indigestion
___	___	Heart attack (date) _____	___	___	High Blood Pressure
___	___	Hepatitis	___	___	Irritable Colon
___	___	Irregular Menstrual Flow	___	___	Kidney Disorders
___	___	Jaw Pain	___	___	Liver/Gallbladder problems
___	___	Kidney Stones	___	___	Loss of Bladder Control
___	___	Loss of Appetite	___	___	Mid Back Pain
___	___	Low Back Pain	___	___	Neck Pain
___	___	Muscular In coordination	___	___	Pain in lower leg or knee
___	___	Pain in ankle or foot	___	___	Pain in upper leg or hip
___	___	Pain in upper arm or elbow	___	___	PMS
___	___	Painful Urination	___	___	Prostate Problems
___	___	Profuse Menstrual Flow	___	___	Rheumatoid Arthritis
___	___	Rapid Heart Beat	___	___	Shoulder Pain
___	___	Scoliosis	___	___	Swelling, stiffness of joint(s)
___	___	Stroke (date) _____	___	___	Tumor, Explain _____
___	___	Tinnitus (ear noises)	___	___	Visual Disturbances
___	___	Ulcer	___	___	Other _____
___	___	Wrist Pain	___	___	

Have you or your family had:

Yes	No	
___	___	Cancer
___	___	Rheumatoid Arthritis
___	___	Epilepsy
___	___	Diabetes
___	___	Chronic Back Problems
___	___	Heart Problems
___	___	Chronic Headaches
___	___	Lung Problems
___	___	High Blood Pressure

Present Weight _____ Height _____
 Medications _____

Additional Information _____

