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:*

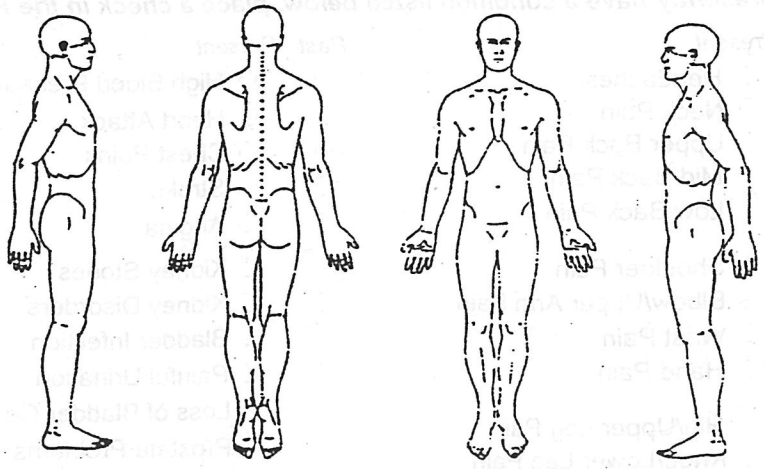
_____

_____

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 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. 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:* _____ ③ CT Scan *date:* _____
② MRI *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* _____

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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		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Use Tobacco Products
						☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain				☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite	*Females Only*		
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			
			☐	☐	Ulcer	☐	☐	Birth Control Pills
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis						
			☐	☐	Cancer	*Other Health Problems/Issues*		
☐	☐	General Fatigue	☐	☐	Tumor			
☐	☐	Muscular Incoordination				☐	☐	
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	
☐	☐	Dizziness	☐	☐	Chronic Sinusitis			

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* _____

New Patient Contact Information, Release and Consent Form

Patient Name _____ **Gender M / F Date** _____

Please list all Cell/Home/Work # _____

Address _____

City, State, and Zip _____

Email Address _____

D.O.B. _____ **Employer** _____

SSN _____ **Primary Care Physician/Clinic** _____

Emergency contact name _____ **Phone #** _____

How did you learn about this clinic? _____

If insurance is through a spouse or guardian, please provide us with this information:

Spouse/Guardian Name _____ **D.O.B.** _____ **SSN** _____

Is your pain a result of an accident or workman's comp case? Y/N

I authorize the doctor(s) to perform such diagnostic procedures & administer whatever treatment is necessary to treat my present problem or illness. I understand & accept that I am responsible for all charges notwithstanding denial, reduction or benefit, or failure to pay on the part of my insurance company. I authorize any information concerning my health & services rendered to be released to my insurance company and/or attorney. I understand that my private information will not be shared with anyone else without my permission in writing. I authorize that insurance payments for my services are paid directly to Barry Road Chiropractic.

Fees, co-pays, and deductibles are due payable at the time of your appointment. We accept cash, checks, charge, and debit. As a service to our patients we will prepare and file both primary and secondary insurance provided that we have current identifying information.

Disability/Additional Insurance Forms - We will be happy to complete your disability/additional insurance forms for a $25.00 charge due at the time of service

Good faith estimate of charges for self pay patients: We are currently running a special that applies to new patient visits Monday through Friday. All first day services are $35 without filing insurance. If you wish us to file insurance or if your new patient visit is on Saturday the fee for first day services is $75.

I hereby acknowledge that I have read, understand, & agree to the terms of this document relating to insurance coverage & payment of my bill.

Patient Signature **Date**

_____