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)

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

CHIPPEWA CHIROPRACTIC CLINIC
LOUIS D'AMICO, DC

AUTO ACCIDENT REPORT

NAME ____ **DOB** ____/____/_______ **DATE** _____/_____/_____

ACCIDENT DATE ______/______/_______ **TIME** ________________

STATE/ LOCATION OF ACCIDENT ____

DESCRIBE ACCIDENT IN DETAIL____

____

____

____

____

____

____

____

____

____

DESCRIBE YOUR SYMPTOMS IN DETAIL ____

____

____

____

____

____

____

____

DID YOU REPORT THIS TO YOUR INSURANCE COMPANY ☐ YES ☐ NO

CLAIM NUMBER ____

INSURANCE COMPANY'S ADDRESS ____________________________________

____

____________________________________ **PHONE** ( ) ________________

INSURANCE CONTACT PERSON ____________________________________ **PHONE** ( ) ________________

DO YOU HAVE AN ATTORNEY ☐ YES ☐ NO

ATTORNEY'S NAME ____ **PHONE** ( ) ________________

PATIENT SIGNATURE ____ **DATE** ____________________

AUTO ACCIDENT HISTORY FORM

PATIENT NAME ____ **DOB** ____/____/_______

ARE YOU CURRENTLY OFF WORK DUE TO THIS ACCIDENT ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ____

TYPE OF WORK ☐ OFFICE/ CLERICAL ☐ LIGHT LABOR ☐ MODERATE LABOR ☐ HEAVY LABOR

DO YOU HAVE ANY PREVIOUS WORK COMP INJURIES ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ____

DO YOU HAVE ANY PREVIOUS AUTO ACCIDENT INJURIES ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ____

DO YOU HAVE ANY PREVIOUS SPORTS OR OTHER INJURIES TO THE HEAD, NECK, OR BACK ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ____

WAS THE ACCIDENT ON-THE-JOB ☐ YES ☐ NO

YOU WERE ☐ DRIVER ☐ FRONT SEAT PASSENGER ☐ REAR SEAT PASSENGER
☐ MOTORCYCLE OPERATOR ☐ MOTORCYCLE PASSENGER ☐ OTHER ___________________

VEHICLE DRIVEN BY ____

YOUR VEHICLE - YEAR __________________ **MAKE** ____________________________ **MODEL** ______________________

YOUR ESTIMATED SPEED AT MOMENT OF ACCIDENT ____MPH ☐ STOPPED ☐ SLOWING ☐ACCELERATING

OTHER VEHICLE (IF APPLICABLE) YEAR _____________ **MAKE** ___________________ **MODEL** ___________________

TIME OF DAY ☐ DAYLIGHT ☐ DAWN ☐ DUSK ☐ DARK

ROAD CONDITIONS ☐ DRY ☐ DAMP ☐ WET ☐ SNOW ☐ ICE ☐ OTHER _______________________

HEAD RESTRAINTS ☐ NONE ☐ INTEGRAL TYPE ☐ ADJUSTABLE TYPE ☐ **UP** ☐ **DOWN** ☐ **DON'T KNOW**

IF ADJUSTABLE, WAS THE POSITION ALTERED BY THE ACCIDENT ☐ YES ☐ NO

WAS THE SEAT BACK ADJUSTMENT ALTERED BY THE ACCIDENT ☐ YES ☐ NO

WAS THE SEAT BROKEN ☐ YES ☐ NO

LAP BELT ☐ WEARING ☐ NOT WEARING ☐ DON'T KNOW

SHOULDER BELT ☐ NONE ☐ WEARING ☐ NOT WEARING ☐ DON'T KNOW

DID AIR BAG DEPLOY ☐ YES ☐ NO

IF YES, WERE YOU STRUCK ☐ YES ☐ NO

BODY POSITION ☐ GOOD ☐ FORWARD LEAN ☐ OTHER ____

HEAD POSITION ☐ FORWARD ☐ LEFT ☐ RIGHT ☐ UP ☐ DOWN

HANDS ☐ ONE ON WHEEL ☐ TWO ON WHEEL ☐ N/A

BRAKES APPLIED ☐ YES ☐ NO

WERE YOU AWARE OF IMPENDING CRASH ☐ YES ☐ NO

PATIENT NAME ____ **DOB**____/____/_______

DURING THE CRASH:

DID YOU STRIKE ANY PARTS OF THE VEHICLE ☐ YES ☐ NO

IF YES, DESCRIBE ____

DID THE VEHICLE STRIKE ANY OBJECTS AFTER THE CRASH ☐ YES ☐ NO

IF YES, DESCRIBE ____

WERE YOU WEARING A HAT OR GLASSES ☐ YES ☐ NO

IF YES, WERE THEY STILL ON AFTER THE CRASH ☐ YES ☐ NO

DID YOU LOSE CONSCIOUSNESS ☐ YES ☐ NO

IF YES, FOR HOW LONG ____

ESTIMATED PROPERTY DAMAGE TO YOUR VEHICLE $____

ESTIMATED DAMAGE TO OTHER VEHICLE ☐ NONE ☐ MINIMAL ☐ MODERATE ☐ MAJOR

WERE POLICE ON SCENE ☐ YES ☐ NO

IF YES, WAS A REPORT MADE ☐ YES ☐ NO

AFTER THE CRASH:

SYMPTOMS ☐ HEADACHE ☐ DIZZINESS ☐ NAUSEA ☐ CONFUSION/ DISORIENTATION ☐ NECK PAIN ☐ PARESTHESIA(S)

IF YES, WHERE ____

EXTREMITY PAIN ☐ YES ☐ NO

IF YES, DESCRIBE ____

BACK PAIN ☐ YES ☐ NO

IF YES, DESCRIBE ____

WHEN DID SYPMTOMS FIRST APPEAR ☐ IMMEDIATELY ☐ LATER - HOW MUCH LATER _______HRS

WHICH SYPMTOMS APPEARED WHEN? ____

WHERE DID YOU GO AFTER THE ACCIDENT ☐ HOME ☐ WORK ☐ HOSPITAL ☐ YOUR DOCTOR

MODE OF TRANSPORTATION ____

IN THE SPACE PROVIDED BELOW PLEASE **DRAW** A DIAGRAM OF THE ACCIDENT