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: WORK ACCIDENT YES NO _____/_____/_____
(PLEASE CIRCLE) 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 _____

_____

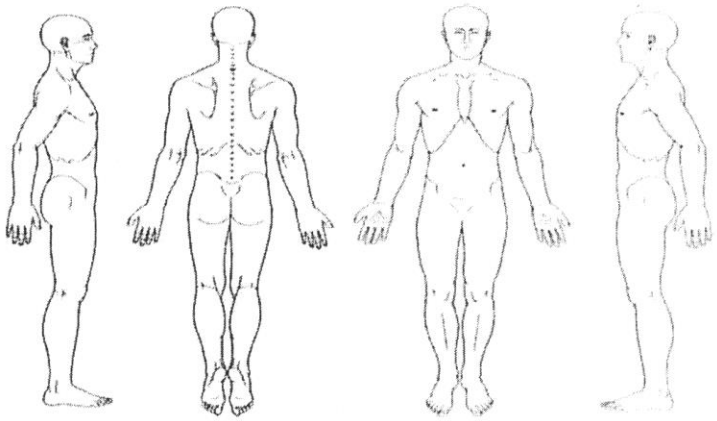
a. When did your symptoms start? _____

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 ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

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 ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

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

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed 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 (OTHER THAN 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 REGULARLY 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

WORK-RELATED ACCIDENT REPORT

NAME _____ **DATE** _____/_____/_____

ACCIDENT DATE _____/_____/_____ **TIME** _____

LOCATION ACCIDENT OCCURRED _____

DESCRIBE ACCIDENT IN DETAIL_____

_____

_____

_____

_____

_____

_____

DESCRIBE YOUR SYMPTOMS IN DETAIL _____

_____

_____

_____

_____

_____

_____

ANY PRIOR WORK COMP INJURIES/HISTORY _____

_____

_____

_____

DID YOU REPORT THIS TO YOUR EMPLOYER □ YES □ NO

IS THIS INJURY WORK RELATED □ YES □ NO

DOES YOUR EMPLOYER HAVE A LIST OF AT LEAST 6 GEOGRAPHICALLY ACCESSIBLE HEALTH CARE PROVIDERS PROMINENTLY POSTED AT WORK □ YES □ NO

IS THERE A CHIROPRACTOR ON THIS LIST □ YES □ NO □ UNKNOWN

WERE YOU GIVEN A PERSONAL NOTICE OF THE LIST BEFORE YOU EVER HAD A WORK-RELATED INJURY □ YES □ NO

EMPLOYER'S ADDRESS _____

_____

_____ **PHONE** ( ) _____

EMPLOYER CONTACT PERSON _____ **PHONE** ( ) _____

PATIENT SIGNATURE _____ **DATE** _____

WORKMAN'S COMPENSATION EXPLANATION

TO OUR PATIENTS:

Because you have just suffered a work-related injury, we would like for you to understand how your case will be handled in our office. The first thing that you need to know is that the insurance carrier for your employer is financially responsible ONLY for treatment of your physical condition which is a result of employment-related incident. Your workers' compensation insurance will pay for treatment which restores your health to a pre-injury status.

You may be experiencing symptoms or problems that you suffered prior to your injury, and these may be contributing to your injury, so a judgment will be made as to what extent these factors have on your present injury. We will advise your workers' compensation insurance carrier as to the apportionment of these factors. It is very important for you to follow my orders and keep your scheduled appointments. The Workers' Compensation Law requires that if you do not receive the care that is necessary for your case your workers' compensation benefits must be discontinued and your case closed. It is also very important to notify your employer and this office of any re-injury or aggravations during your course of treatment.

We thank you warmly for the opportunity to serve you and welcome any questions that you may have concerning your case.

Sincerely,

Dr. Louis D'Amico, DC

I HAVE READ AND UNDERSTAND THE ABOVE POLICY

_____ _____

PATIENT'S SIGNATURE DATE