# 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** _____

_____

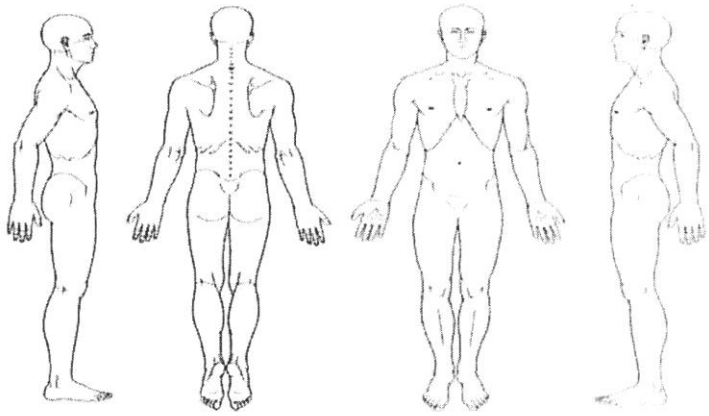
*a. When did your symptoms start?* _____

*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 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