

Patient History

Date _____

Name: _____ Social Sec#: _____
 Address _____ Phone(H) _____
 City, St., Zip _____ Phone(C) _____
 Date of Birth: _____ Age _____ Spouse's Name: _____
 Employer: _____ Phone(W) _____
 Address: _____ Who may we thank for referring you?
 City, St., Zip: _____
 Insurance Carrier: _____ Policy #: _____
 Email Address: _____
 Is this episode of pain a result of an accident? _____ If yes, when? _____
 How did the accident occur ___ Auto Accident ___ On the Job ___ Sports ___ Other ___
 List any previous injuries, accidents, or illnesses including hospitalizations: _____

Symptoms

With this episode of pain was the onset ___ gradual or ___ sudden?

Please indicate which activities worsen your pain:

- | | | |
|-----------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Intercourse | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Bending | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Reclining | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Alcohol | <input type="checkbox"/> House Cleaning |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tension | <input type="checkbox"/> Other |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Coughing | |

Do you have any associated symptoms? ___ Nausea ___ Headaches ___ Vomiting
 How often do you stop your activities due to pain to sit or lie down? ___ Occasionally
 ___ 1 time a day ___ several times a day ___ most of the day

Functional/ Recreational History

Please indicate how long, in hours, you can:

Sit continuously ___ hrs. Stand continuously ___ hrs.
 Drive continuously ___ hrs. Walk continuously ___ hrs.

Do you have difficulty with?

Dressing ___ If yes, please specify _____
 House/Yard work ___ If yes, please specify _____
 Your occupation ___ If yes, please specify _____

List things you enjoyed doing prior to your pain, that you are now unable to do: _____

Do you currently exercise? _____ If yes, How often? _____

The information provided is true and correct to the best of my knowledge.

Signature _____ Date: _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

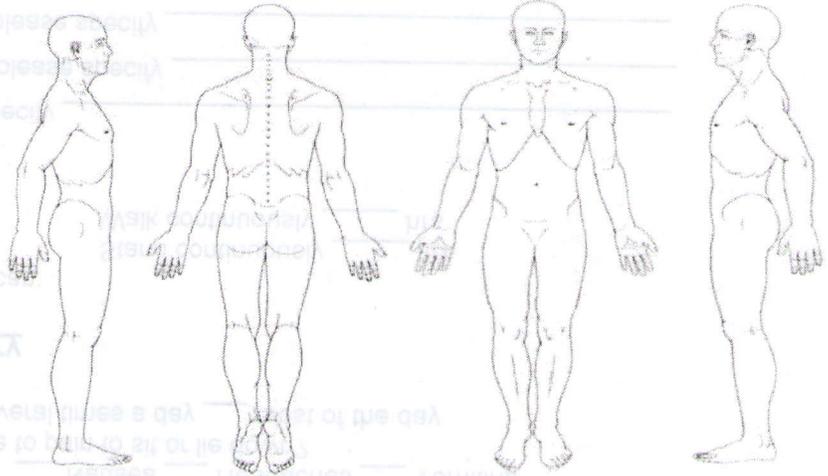
a. When did your symptoms start? _____

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
- (2) Dull ache
- (3) Numb
- (4) Shooting
- (5) Burning
- (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: _____ (2) MRI date: _____ (3) CT Scan 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 _____