# Confidential Health History Form

*WELCOME!*

Chiropractic Plus Pain to Wellness Center, PLLC

**PERSONAL INFORMATION**

***For Office Use Only***
***ID #***

*Please Present Insurance Cards & Photo Identification to Copy for Files.*

***PLEASE PRINT CLEARLY! Thank you! SIGN ALL PAGES!***

First visit to our office? ___Yes ___No

Title (check one): ___Mr. ___Mrs. ___Ms. ___Miss ___Dr. Other_____

PATIENT NAME: First_____ MI_____ Last_____

IF MINOR, Parent/Guardian Name:_____
PRINT: First MI Last

Address: _____
Street / Apt City State Zip

Phone: Cell:_____ Home:_____ Work:_____

Email (We do not share/Please Print): _____

Your Age:_____ Date of Birth:_____ /_____ / _____ Your Gender: ___Female ___Male _____

Your Social Security Number:_____

You are: ___Divorced ___Married ___Live-in Partner ___Single ___Separated ___Widowed

Spouse/Partner Name:_____ Phone:_____
PRINT: First MI Last

Names / Ages of Children:_____

Females: Are you pregnant? ____No ____Yes If Pregnant, # Weeks_____ / Due Date: _____

**EMPLOYMENT INFORMATION:**

Employment Status: ___Employed ___Unemployed ___FT Student ___PT Student Other_____

Occupation:_____

Occupational Activities (check best description/s of your job):

___Administration ___Business Owner ___Clerical/Secretary ___Computer User
___Construction ___Home Services ___Health Care ___Food Service Industry
___Daycare/Childcare ___Executive/Legal ___Housekeeper ___Manufacturing
___Heavy Equipment Operator ___Light Manual Labor ___Medium Manual Labor ___Heavy Manual Labor

Other Job Description_____

Employer:_____ Employer Address: _____

City:_____ State:_____ Zip Code:_____

**EMERGENCY CONTACT:**

Name:_____ Relationship to Patient:_____

Home Phone:_____ Cell Phone:_____ City/State:_____

**HOW DID YOU HEAR ABOUT OUR OFFICE?**___Internet ___Insurance ___Friend/Family Other_____

Name & Address of person we can thank for referral:

_____

***PATIENT SIGNATURE*** _____ ***DATE***_____

***IF MINOR: PARENT/GUARDIAN NAME LISTED ABOVE***
***SIGNATURE & CONSENT TO EXAMINE/TREAT MINOR*** _____

**Attending Doctor's Signature**_____

**Date**_____

## Confidential Health History Form

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**REVIEW OF SYSTEMS**

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**PATIENT NAME**: First_____ MI_____ Last_____

**IF MINOR**, Parent/Guardian Name:_____
PRINT: First MI Last

**SIGNATURE**:_____ **DATE**:_____

**Review of Systems** – (**Check box** if you have had trouble with any of the following, **circle NO if none**)

| **Cardiovascular** | Past | Present | No | **Respiratory** | Past | Present | No | **Allergic/Immunologic** | Past | Present | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Poor Circulation | | | | Asthma | | | | Hives | | | |
| Aortic Aneurism | | | | Tuberculosis | | | | Other Skin Disorder | | | |
| Heart Disease | | | | Short Breath | | | | Immune Disorder | | | |
| Heart Attack | | | | Emphysema | | | | HIV/AIDS | | | |
| Chest Pain | | | | Cold/Flu | | | | Allergy Shots | | | |
| Pace Maker | | | | Cough | | | | Cortisone Use | | | |
| Jaw Pain | | | | Wheezing | | | | | | | |
| Atrial Fib | | | | | | | | **Ear, Nose and Throat** | Past | Present | No |
| Swelling of legs | | | | **Eyes** | Past | Present | No | Difficulty Swallowing | | | |
| | | | | Glaucoma | | | | Dizziness | | | |
| | | | | Double Vision | | | | Hearing Loss | | | |
| **Genitourinary** | Past | Present | No | Blurred Vision | | | | Ear Aches | | | |
| Kidney Disease | | | | | | | | Sore Throat | | | |
| Burn Urination | | | | **Psychiatric** | Past | Present | No | Nosebleeds | | | |
| Often Urination | | | | Depression | | | | Bleeding Gums | | | |
| Blood in Urine | | | | Anxiety | | | | Sinus Infections | | | |
| Kidney Stones | | | | Stress | | | | Sore Throat | | | |
| Lower Side Pain | | | | | | | | | | | |
| | | | | **GastroIntestine** | Past | Present | No | **Endocrine** | Past | Present | No |
| **Neurologic** | Past | Present | No | Gall Bladder | | | | Thyroid | | | |
| Stroke | | | | Liver Problems | | | | Diabetes | | | |
| Brain Aneurysm | | | | Constipation | | | | Hair Loss | | | |
| Numbness | | | | Diarrhea | | | | Menopausal | | | |
| Severe Headaches | | | | Bowel Problems | | | | Menstrual | | | |
| Pinched Nerves | | | | Ulcers | | | | Vaginal Pain/Infection | | | |
| Parkinson's | | | | Nausea/ Vomiting | | | | Breast Pain/Lumps | | | |
| Carpal Tunnel | | | | Hiatal Hernia | | | | Prostate/Sexual Dysfxn | | | |
| Vertigo | | | | Poor Appetite | | | | | | | |
| | | | | Hemorrhoids | | | | | | | |
| | | | | | | | | | | | |
| **Constitutional** | Past | Present | No | **Hematologic** | Past | Present | No | **Musculoskeletal** | Past | Present | No |
| | | | | Hepatitis | | | | Gout | | | |
| Weight Loss/Gain | | | | Blood Clots | | | | Arthritis | | | |
| Low Energy | | | | Cancer | | | | Joint Stiffness | | | |
| Sleep Problems | | | | Bruising | | | | Muscle Weakness | | | |
| | | | | Bleeding | | | | Osteoporosis | | | |
| | | | | Fever, Chills | | | | Broken Bones | | | |
| | | | | Sweating | | | | Joints Replaced | | | |
| | | | | Anemia | | | | | | | |
| | | | | | | | | | | | |

**Other Medical Condition:**_____



**Attending Doctor's Signature** _____ **Date**_____

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## MEDICATIONS / SURGERIES / FAMILY & SOCIAL HISTORY

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**PATIENT NAME**: First_____ MI_____ Last_____

**IF MINOR**, Parent/Guardian Name:_____
PRINT: First MI Last

**SIGNATURE**:_____ **DATE**:_____

**Surgeries:** (Check all that apply to you)
___Brain ___Appendectomy ___Cardiovascular procedure ___Hysterectomy ___Prostate
___Cervical spine ___Thoracic spine ___Lumbar spine ___Gall Bladder
___Carpal Tunnel ___Shoulder ___Knee ___Foot/Ankle ___Joint Replacement
___Gastro-intestinal ___Uro-genital ___Hernia Other _____
_____

**Use of:**
___Orthotics/Shoe Inserts ___Cane ___Walker ___Mobile Cart Assist Other_____

**Allergies:** (Check all that apply to you)
___Eggs ___Fish and Shellfish ___Milk or Lactose ___Peanuts ___Wheat/Glutens
___Soy ___Sulfites Other _____

**Social History:** (Check all that apply to you)
Caffeine use: ___occasional ___often ___never cups/day_____
Drink Alcohol: ___occasional ___often ___never drinks/week_____
Exercise: ___occasional ___often ___never type_____
Chew Tobacco: ___occasional ___often ___never
Cigarettes: ___less than 1 pack/day ___more than 1 pack/day ___never
Wear Seat Belts: ___occasional ___always ___never
Other _____

**Family History:** (Grandparents-Parents-Siblings / Check all that apply)

| | | | |
|---|---|---|---|
| Arthritis: | ___Parent | ___Sibling | Other _____ |
| Cancer: | ___Parent | ___Sibling | _____ |
| Diabetes: | ___Parent | ___Sibling | _____ |
| Heart Disease: | ___Parent | ___Sibling | _____ |
| Hypertension: | ___Parent | ___Sibling | _____ |
| Stroke: | ___Parent | ___Sibling | _____ |
| Thyroid: | ___Parent | ___Sibling | |

**BIOCHEMICAL HEALTH / CURRENT MEDICATIONS & NUTRITIONAL SUPPLEMENTS (Continue other side if needed)**

Please list ALL **DRUGS** you currently take or have taken in the past 6 months:
Name _____ For what condition? _____
Name _____ For what condition? _____
Name _____ For what condition? _____
Name _____ For what condition? _____
Name _____ For what condition? _____
Name _____ For what condition? _____

Please list all **NUTRITIONAL SUPPLEMENTS, VITAMINS, HOMEOPATHIC REMEDIES** you presently take:
_____
_____
_____

**Your Primary Care Physician**:

Name_____City/State_____Phone_____

**Date of Your Last Exam:** Medical:_____ Chiropractic:_____

Rev 11/16/2015

**Attending Doctor's Signature** _____ **Date**_____

# Confidential Health History

Chiropractic Plus Pain to Wellness Center PLLC

## PHQ - PATIENT HEALTH QUESTIONNAIRE

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***Patient Name*** _____ ***Date*** _____

***1. Describe your symptoms*** _____

_____

_____

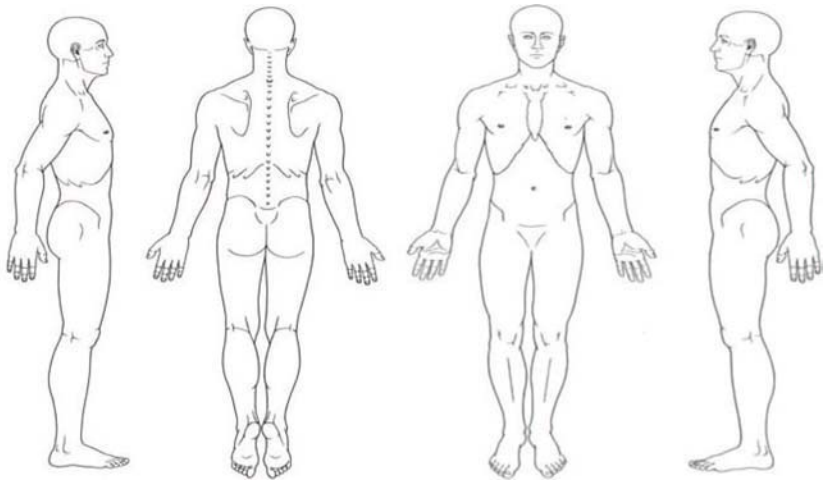
*a. Date your symptoms began:* _____

*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)*Plan

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*** _____

# Confidential Health History Form

Chiropractic Plus Pain to Wellness Center PLLC

## ADL, EMPLOYMENT, AND RECREATION INFORMATION

***For Office Use Only***
***ID #***

**PATIENT NAME**: First_____ MI___ Last_____

**IF MINOR**, Parent/Guardian Name:_____

**SIGNATURE**:_____ **DATE**:_____

**Description of Work:** _____

**Condition's Effect On Job Performance:** ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability) ☐ **Mod/Sev** (limited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

**Daily Activities: Effects of Current Condition on Performance**

| | | | | |
|---|---|---|---|---|
| Bending: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Care –Infirm Family: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Carrying Groceries: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Change Posn–Sit-Stand: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Climb Stairs: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Driving: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Extended Computer Use: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Feeding: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Household Chores: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Kneeling: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Lift Children: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Lifting: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Pet Care: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Reading (Concentration): | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Self Care–Bathing: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Self Care–Dressing: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Self Care–Shaving: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Sexual Activities: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Sleep: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Static Sitting: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Static Standing: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Walking: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |
| Yard Work: | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (Limited) | ☐ **Sev** Unable to Perform |

**Recreational Activity: Effects of Current Condition on Performance**

| | | | | |
|---|---|---|---|---|
| _____ | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (limited) | ☐ **Sev** Unable to Perform |
| _____ | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (limited) | ☐ **Sev** Unable to Perform |
| _____ | ☐ **No Effect** | ☐ **Mild** Painful (Can do) | ☐ **Mod** Painful (limited) | ☐ **Sev** Unable to Perform |

**What activities would you like to do that you cannot do because of your pain, illness, condition?**

_____

_____

**Attending Doctor's Signature** _____ **Date**_____

**Outcomes Assessment Tool Used** _____ **Score** _____

_____ **Score** _____

## Confidential Health History Form

Chiropractic Plus Pain to Wellness Center, PLLC

**HIPAA ACKNOWLEDGEMENT / INSURANCE NFORMATION**

***For Office Use Only***
***ID #***

**PATIENT NAME**: First_____ MI_____ Last_____

**IF MINOR**, Parent/Guardian Name:_____
PRINT: First MI Last

**SIGNATURE**:_____ **DATE**:_____

**Payment/Insurance Information:** *Please Present Insurance Cards & Photo Identification to Copy*

**Is this a claim to file with:** ___Health Insurance ___Auto Insurance ___Worker's Comp ___Medicare
Other _____

**PERSONAL HEALTH INSURANCE** *(Please Print)***:**
Insurance Company:_____

Policy Holder Name:_____ Relationship of Policy Holder to You: _____

Policy Holder's Date of Birth _____ / _____ / _____ Policy Holder's Phone:_____

Insur. Card ID # _____ Group #_____ Primary Care Physician _____

**AUTO/VEHICLE ACCIDENT** *(Please Print)***:**

Auto Accident Date:_____ / _____ / _____ Accident State: ___NC Other_____

Your Med Pay Auto Policy Carrier: _____ Your Auto Policy #_____

Your Carrier Contact Name and Phone:_____

At-Fault/Other Driver Name:_____

At-Fault Auto Policy Company: _____ Their Auto Policy #_____

At-Fault Carrier Contact Name and Phone:_____

**WORKER'S COMPENSATION INJURY:**

Have you filed an injury report with your employer?__Yes __No Date: ____/____/____ Time: _____am / pm

**~~~~~~~~~~~~~~~~~~~~~~~~HIPAA PRIVACY PRACTICES~~~~~~~~~~~~~~~~~~~~~~~~~~**

**I acknowledge that I have seen online, received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.**

**Print Patient's Name** _____

**Patient's Signature** _____ **Date**_____

**Consent to Treat a Minor: (Minor's Printed Name)** _____

**Parent/Guardian Signature Authorizing Care** _____ **Date**_____

**SIGNATURE OF PHYSICIAN** _____ **Date**_____