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_____

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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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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

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PHQ - PATIENT HEALTH QUESTIONNAIRE

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Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

_____

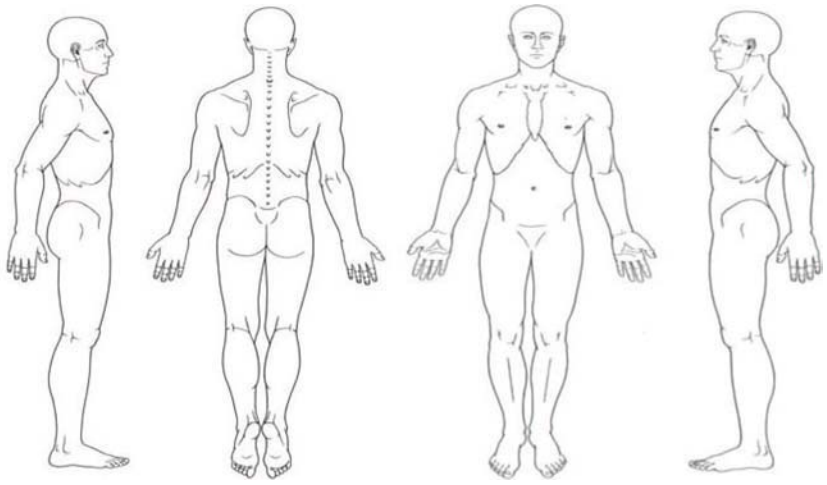
a. Date your symptoms began: _____

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*** _____

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ADL, EMPLOYMENT, AND RECREATION INFORMATION

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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** _____

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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**_____