PATIENT'S PRESENT COMPLAINTS

SOUTH HALL CHIROPRACTIC CLINIC

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Social Security # _____ Driver Lic. # _____

Age _____ Birthdate ____/____/____ Sex M / F Status M S D W No. of Children _____

Employer _____ Occupation _____ Wk. Ph. _____ Years Employed ____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Occupation _____ Employer _____ S.S. # _____

Insurance Co. _____ Insurer's Name _____

WHO REFERRED YOU TO OUR OFFICE? _____ WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)? _____

PLEASE DESCRIBE YOUR CURRENT PROBLEM. _____

HOW DID YOUR PROBLEM BEGIN? **DATE PROBLEM BEGAN** ____/____/____. _____

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION IN THE PAST? (Surgery, Medications, Injections, Therapy, Chiropractic)

HAVE YOU HAD X-RAYS, MRI OR OTHER TESTS FOR THIS CONDITION? WHAT TESTS AND WHEN? _____

Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the Job ❑ Auto Accident ❑ Personal Injury ❑ Other: _____

Have you retained an attorney? ❑ No ❑ Yes Name & Address _____

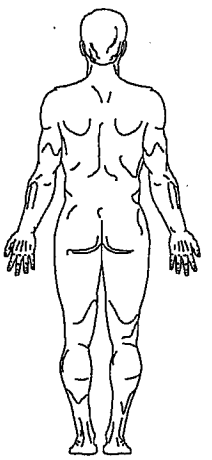
How bad is your pain? (Circle One) 0 1 2 3 4 5 6 7 8 9 10

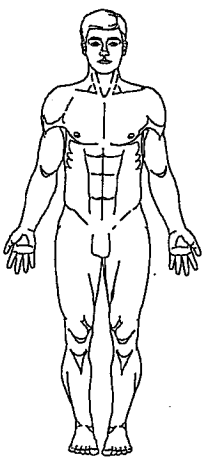
No Pain ***Unbearable Pain***

How often are your symptoms present? ❑ Constantly ❑ Frequently ❑ Occasionally ❑ Intermittently

Describe your ***current*** pain/symptoms:	❑ Sharp/Stabbing	❑ Throbbing	❑ Aches
	❑ Dull	❑ Soreness	❑ Weakness
	❑ Numbness	❑ Shooting	❑ Gripping
	❑ Burning	❑ Tingling	❑ Other _____
Since it began, is your problem:	❑ Improving	❑ Getting Worse	❑ No Change
What makes your problem better?	❑ Nothing	❑ Lying Down	❑ Walking
	❑ Standing	❑ Sitting	❑ Movement
	❑ Exercise	❑ Inactivity/rest	❑ Other _____
What makes your problem worse?	❑ Nothing	❑ Lying Down	❑ Walking
	❑ Standing	❑ Sitting	❑ Movement
	❑ Exercise	❑ Inactivity/rest	❑ Other _____
Can you perform your daily home activities?	❑ Yes	❑ Yes, only with help	❑ Not at all
Do you exercise?	❑ Yes, almost daily	❑ Yes, occasionally	❑ Not at all
Describe your job requirements:	❑ Mainly sitting	❑ Light Labor	❑ Heavy Labor
Can you perform your daily work activities?	❑ Yes, all activities	❑ Only some	❑ Not at all
Describe your stress level:	❑ None to mild	❑ Moderate	❑ High

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING





Patient Signature **X** _____ Date: _____

SOUTH HALL
CHIROPRACTIC CLINIC

PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ Patient ID# _____

If you have ever had a listed symptom in the ***past***, please check that symptom in the ***Past Column.*** If you are ***presently*** troubled by a particular symptom, check that symptom in the ***Present Column.*** **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT YOU RECEIVE.**

Past	Present	
❑	❑	Abdominal Pain
❑	❑	Abdominal Weight ❑ Gain ❑ Loss
❑	❑	Angina
❑	❑	Anorexia
❑	❑	Aortic Aneurysm
❑	❑	Arthritis
❑	❑	Asthma
❑	❑	Bladder Infection
❑	❑	Blood Disorder
❑	❑	Breast ❑ Soreness ❑ Lumps
❑	❑	Cancer, Explain _____
❑	❑	Chest Pains
❑	❑	Chronic Cough
❑	❑	Chronic Sinusitis
❑	❑	Colitis
❑	❑	Constipation/irregular bowel habits
❑	❑	Convulsions
❑	❑	Diabetes
❑	❑	Depression
❑	❑	Dermatitis/Eczema/Rash
❑	❑	Difficulty in Swallowing
❑	❑	Dizziness
❑	❑	Emphysema (chronic lung disorders)
❑	❑	Endometriosis
❑	❑	Epilepsy
❑	❑	Excessive Thirst
❑	❑	Fainting
❑	❑	Frequent Urination
❑	❑	General Fatigue
❑	❑	Hand Pain (R___ L___)
❑	❑	Headache
❑	❑	Heart Attack (date) _____
❑	❑	Heartburn/Indigestion
❑	❑	Hepatitis
❑	❑	High Blood Pressure
❑	❑	Irregular Menstrual Flow
❑	❑	Irritable Colon
❑	❑	Jaw Pain
❑	❑	Kidney Disorders (by condition)
❑	❑	Kidney Stones
❑	❑	Liver / Gallbladder problems
❑	❑	Loss of Appetite

Past	Present	
❑	❑	Loss of Bladder Control
❑	❑	Low Back Pain
❑	❑	Mid Back Pain
❑	❑	Muscular Incoordination
❑	❑	Neck Pain
❑	❑	Pain in Ankle or Foot (R__ L__)
❑	❑	Pain in Lower Leg or Knee (R__ L__)
❑	❑	Pain in upper Arm or Elbow (R__ L__)
❑	❑	Pain in Upper Leg or Hip (R__ L__)
❑	❑	Painful Urination
❑	❑	PMS
❑	❑	Profuse Menstrual Flow
❑	❑	Prostate Problems
❑	❑	Rapid Heart Beat
❑	❑	Rheumatoid Arthritis
❑	❑	Scoliosis
❑	❑	Shoulder Pain (R__ L__)
❑	❑	Stroke (date) _____
❑	❑	Swelling, Stiffness of Joint(s)
❑	❑	Tinnitus (Ear Noises)
❑	❑	Tumor, Explain_____
❑	❑	Ulcer
❑	❑	Visual Disturbances
❑	❑	Wrist Pain (R__ L__)
❑	❑	Other _____

If a family member has had any of the following, please mark the appropriate box:

❑ Cancer
❑ Rheumatoid Arthritis
❑ Diabetes
❑ Heart Problems
❑ Lung Problems
❑ High Blood Pressure _____
❑ Epilepsy
❑ Chronic Back Problems
❑ Chronic Headaches
❑ Lupus
❑ Other _____

Yes	No	
❑	❑	Do you have a permanent disability rating? Location_____
❑	❑	Date rating received __/__/__
❑	❑	Rating Percentage_____%

Present Weight _____ **pounds** **Height** _____ **feet** _____ **inches**

Please check any of the following that apply to you.

Past	Present	
❑	❑	Pregnancy, # births _____
❑	❑	Birth Control Pills, type _____
❑	❑	Medications (list if not listed elsewhere) _____ _____
❑	❑	Hospitalizations/Surgical Procedures (list if not described elsewhere)

Past	Present	
❑	❑	Tobacco
❑	❑	Alcohol
❑	❑	Drug or Alcohol Dependence
❑	❑	Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day _____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately when ever I have changes in my health condition or health plan coverages in the future.

Patient's Signature: X_____ Date: _____