Patient Introduction Card

No. _____ Date: _____

Name (Mr. Mrs. Miss Ms.): _____ Home Phone: (___) _____

Email Address (ex: name@email.com): _____ Cell Phone: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Married ☐ Single ☐ Other: _____ Age: _____ Date of Birth: ____/____/____

Spouse's Employer _____ Spouse's DOB ____/____/____

Emergency Contact Name & Phone Number: _____

Occupation: _____ Employer: _____

Office Address: _____ Office Phone: (___) _____

Previous Chiropractic Care? ☐ YES ☐ NO If YES, Doctor's Name: _____

Name of your Insurance Company: _____

Major Complaint: _____ Social Security No: _____

Who (or what source) referred you? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged.

Form 32/C

Patient Health Questionnaire

Patient No. _____

Patient Name _____ *Date* _____

1. Describe your current symptoms (Begin with what bothers you the most) _____

_____

2. When did your symptoms begin? _____

3. What activities make your symptoms worse?

(1) Ice (3) Rest (5) Sitting (7) Medication

(2) Heat (4) Activity (6) Standing (8) Other

4. What activities make your symptoms better?

(1) Ice (3) Rest (5) Sitting (7) Medication

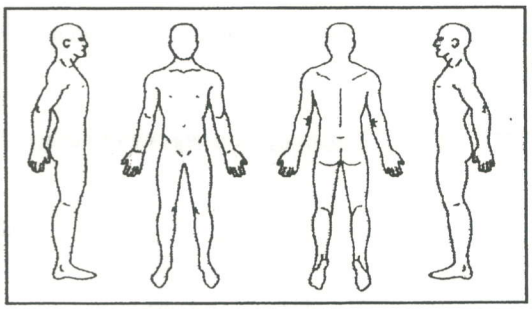
(2) Heat (4) Activity (6) Standing (8) Other

5. What describes the nature of your symptoms?

(1) Sharp (3) Numb (5) Burning

(2) Dull Ache (4) Shooting (6) Tingling

6. Indicate where you have pain or other symptoms. →



7. What describes the severity of your symptoms?

None 1 2 3 4 5 6 7 8 9 10 Severe

8. How are your symptoms changing?

(1) Getting Better

(2) Not Changing

(3) Getting Worse

9. Who else have you seen for your current symptoms?

(1) No One (3) Medical Doctor (5) This Office

(2) Other Chiropractor (4) Physical Therapist (6) Other _____

10. What tests have you had for your symptoms? (0) None

(1) X-rays date: _____ (3) CT Scan date: _____

(2) MRI date: _____ (4) Other date: _____

11. What other forms of care have you tried for your current complaint?

(1) Nothing (3) Muscle Relaxer (5) Advil/Tylenol/Aleve, etc. (7) Injections

(2) Pain Medication (4) Ice/Heat (6) Physical Therapy (8) Other: _____

12. What do you feel caused your symptoms?

(1) Fall (2) Car Accident (3) Lifting (4) Don't Know (5) Work (6) Other: _____

13. What activities are affected by your symptoms?

(1) Work/School (3) Sleeping (5) Drive/Riding in Car (7) Golf (9) Exercising

(2) Walking (4) Running (6) House Work (8) Yard Work (10) Other _____

14. Have you had similar symptoms in the past? (Y) Yes When? _____ (N) No

15. (If yes, whom did you see?

(1) No One (3) Medical Doctor (5) This Office

(2) Other Chiropractor (4) Physical Therapist (6) Other _____

16. What is your occupation? (1) Professional/Executive (2) White Collar/Secretarial

(3) Tradesperson (5) Homemaker (7) Retired

(4) Laborer (6) F/T Student (8) Other: _____

17. What is your regular exercise type? (1) None (2) Light (3) Moderate (4) Heavy

For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past.

If you have the conditions listed, place a check in the PRESENT column.

Many of the following conditions respond to chiropractic and acupuncture

	18. PAST	19. PRESENT	
1	( )	( )	Headaches
2	( )	( )	Neck Pain
3	( )	( )	Upper Back Pain
4	( )	( )	Mid Back Pain
5	( )	( )	Low Back Pain
6	( )	( )	Shoulder Pain
7	( )	( )	Elbow/Upper Arm Pain
8	( )	( )	Wrist Pain
9	( )	( )	Hand Pain
10	( )	( )	Hip/Upper Leg Pain
11	( )	( )	Knee/Lower Leg Pain
12	( )	( )	Ankle/Foot Pain
13	( )	( )	Jaw Pain/TMJ
14	( )	( )	Joint Stiffness
15	( )	( )	Arthritis
16	( )	( )	Rheumatoid Arthritis
17	( )	( )	General Fatigue
18	( )	( )	Ringing in Ears
19	( )	( )	Visual Disturbances
20	( )	( )	Dizziness

	PAST	PRESENT	
21	( )	( )	High Blood Pressure
22	( )	( )	Heart Attack
23	( )	( )	Chest Pains
24	( )	( )	Stroke
25	( )	( )	Angina
26	( )	( )	Kidney Stones
27	( )	( )	Kidney Disorder
28	( )	( )	Bladder Infection
29	( )	( )	Painful Urination
30	( )	( )	Loss of Bladder Control
31	( )	( )	Prostate Problems
32	( )	( )	Abnormal Weight Gain/Loss
33	( )	( )	Loss of Appetite
34	( )	( )	Abdominal Pain
35	( )	( )	Ulcer
36	( )	( )	Hepatitis
37	( )	( )	Liver/Gall Bladder Disorder
38	( )	( )	Cancer
39	( )	( )	Tumor
40	( )	( )	Asthma
41	( )	( )	Chronic Sinusitis
42	( )	( )	Seasonal Allergies

	PAST	PRESENT	
43	( )	( )	Diabetes
44	( )	( )	Excessive Thirst/Urination
45	( )	( )	Thyroid Disorder
46	( )	( )	Smoking/Tobacco Use
47	( )	( )	Drug/Alcohol Dependence
48	( )	( )	Food Allergies
49	( )	( )	Depression
50	( )	( )	Frequent Illness
51	( )	( )	Epilepsy
52	( )	( )	Dermatitis/Eczema/Rash
53	( )	( )	HIV/AIDS

Females Only

54	( )	( )	Hot Flashes
55	( )	( )	Hormone Replacement
56	( )	( )	Birth Control Pills
57	( )	( )	Painful Periods/Cramps
58		NO	Are You Pregnant?
		YES	Estimated Due Date

Other Health Problems

59	( )	( )	_____
60	( )	( )	_____
61	( )	( )	_____

20. Primary Care Physician _____ ***20b. Date of Last Medical Physical*** _____

21. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: _____

22. List all prescriptions and over-the-counter medications, nutritional/herbal supplements you are taking:

_____

_____

23. List all the surgical procedures you have had and times you have been hospitalized:

_____

_____

24. Detail any history of trauma to head, neck, or back (automobile accidents, sports injuries, work-related accidents, etc.):

_____

_____

Patient Signature _____ ***Date*** _____