PATIENT HEALTH QUESTIONNAIRE Date: ___________________________

Patient Name: ____ Date of Birth: ______________________

Patient's Address: _____________________________________ City: ________________ State: _______ Zip:___________

Home Phone: __________________ Cell Phone: _______________ Work Phone ______________ E-mail: __________________

Occupation: __________________ Employer: ___________________________ S,S,#: __________________________________

Driver's License # _____________ Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Other # of children _____

Spouse Name: _________________ Spouse Employer: ______________________ Work Phone: _______________

Health Plan: __________________________ Subscriber Name: ____

Relationship: ☐Self ☐Spouse ☐Child ☐Other _______________________

Subscriber ID#: ____________________ Group #: ___________________ Primary Care Physician: _______________________

Patient's Nearest Relative: _____________________________ Phone#: __________________________________

Address: _______________________________________ Relationship: ☐Parent ☐Brother ☐Sister ☐Other:___________________

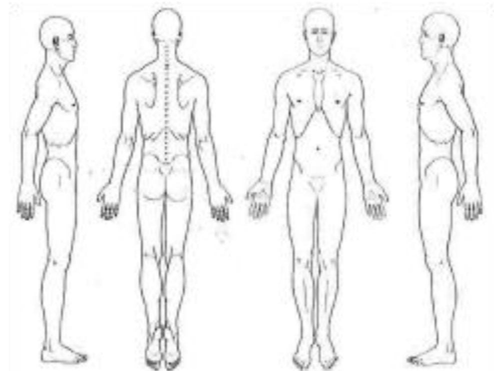
Referred to this office by: _____________________________________

Describe your Symptoms: _____________________________________

____

____

Indicate problem areas on diagram below



When did your symptoms start? _____________________________

How did your symptoms start? ______________________________

____

____

Is this □ Work related? □ Auto related? □ Other accident? □ Other

Current complaint (how do you feel today

____

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable pain

How often do you experience your symptoms?

□ Constantly (76-100% of day) □ Frequently (51-75% of day) □ Occasionally (26-50% of day) □ Intermittently (0-25% of day)

What describes the nature of your symptoms? □ Sharp □ Shooting □ Dull Ache □ Burning □ Numb □ Tingling

How are your Symptoms changing □ Getting better □ Not Changing □ Getting Worse

How much has pain interfered with your normal work (including both work outside the home, and housework).

____

0 1 2 3 4 5 6 7 8 9 10

Not at all Extremely

In general would you say your overall health right now is...□ Excellent □ Very Good □ Good □ Fair □ Poor

Who have you seen for these symptoms? □ No One □ Chiropractor □ Medical Dr. □ Physical Therapist □ Other ___________________

What treatment did you receive and when? ____

What tests have you had and when were they performed?

□ X-rays *date:*_____ □ MRI *date:*_____ □ CT Scan *date:*_____ □ Other __________________ date:_____

PATIENT HEALTH QUESTIONNAIRE

Have you had similar symptoms in the past? □ Yes *date:*__________ □ No
Where did you receive treatment: □ This office □ Chiropractor □ Medical Doctor □ Physical Therapist □ Other _______________
Please check all of the following that apply to you:

□ Recent Fever	□ Prostate Problems	□ Diabetes
□ Menstrual Problems	□ High Blood Pressure	□ Urinary Problems
□ Taking Birth Control Pills	□ Marked Morning Pain/Stiffness	□ Numbness in Groin/Buttocks
□ Numbness in Legs or Feet	□ Numbness in Arms or Hands	□ Head ache
□ Dizziness/Fainting	□ Pain Unrelieved by Position or Rest	□ Pain at Night
□ Osteoporosis	□ Visual Disturbances	□ Epilepsy/Seizures

Give information about any of the following:
□ Stroke (date)______________ □ Corticosteroid Use (Cortisone, prednisone, etc.) □ Abnormal Weight Gain □ Abnormal Weight Loss
□ Currently Pregnant, # weeks ______ □ Cancer/Tumor:_____________________ □ Other Health Problems:________________________
□ Surgeries:____
□ Medications:____
Have you Been treated for any health condition by a physician in the last year? □ Yes □ No Describe ___________________________
____ Date of Last Physical exam: ____________

I certify to the best of my knowledge, the above information is complete and accurate.
I understand and agree that I am personally liable for all charges for services rendered. I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Francis Chiropractic will as a courtesy, will prepare reports and forms to assist me in making collection from the insurance company. It is understood and agreed that the amount paid for x-ray is for examination only, that x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

I hereby authorize Dr. Francis to examine and treat me, as he deems appropriate through the use of Chiropractic Health Care, and give authorization for these procedures to be performed. I understand and agree that the doctor is not responsible for any preexisting medical diagnosed condition, nor for medical diagnosis.

Patient Signature ____ Date: _____________________

Parent or Guardian : ____Date: _____________________

Information taken by: ____ Date: ____________________