

CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.
(Please Print)

Name _____ Date _____ Case No. _____
(last) (first) (middle)

Address _____ Phone _____

City _____ State _____ Zip _____

Age _____ Ht. _____ Wt. _____ Date of Birth _____ Sex _____ Married _____ Single _____ Number of Children _____

Occupation or Profession _____

Employed by _____ Business Phone _____

Name of Spouse _____

Employed by _____ Business Phone _____

Referred by _____

Have you had chiropractic care before? _____ Where? _____

Have you health insurance? _____ What company? _____

Social Security No. _____ Who is responsible for account? _____

(name)

(address)

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

<p style="text-align: center;">Never OCCASIONAL FREQUENT</p>	<p>GENERAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p>MUSCLE & JOINT</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain or stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p>Pain or numbness in:</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p>	<p>GASTRO-INTESTINAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Distension of abdomen</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gall bladder trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach</p> <p>EYES, EARS, NOSE & THROAT</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noises</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection</p> <p>CARDIO-VASCULAR</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p>	<p>RESPIRATORY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p>SKIN</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inability to control kidneys</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection or stones</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p> <p>FOR WOMEN ONLY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive menstrual flow</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopausal symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p>
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CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Goiter			

(Please complete other side)

CASE HISTORY

PLEASE PRINT

Describe major complaints and symptoms -

Date you first noticed symptoms -

Has this happened before? When -

Office Use

- Drugs you now take: Nerve pills Pain killers
 Muscle relaxers "Pep" pills
 Tranquilizers Insulin
 Birth control pills
 other _____

Age of mattress _____ Comfortable Uncomfortable

Are you wearing: Heel lifts Sole lifts Inner soles
 Arch supports

Have you been in an auto accident? Past year Past 5 years
 Over 5 years Never

Have you had any other personal injury or accident? Past year
 Past 5 years Over 5 years None

Have you ever had any mental or emotional disorders? Yes
 No

HAVE YOU EVER:

- Been knocked unconscious?
 Used a crutch, or other support?
 Been treated for a spine or nerve disorder?
 Had a fractured bone?
 Been hospitalized for other than surgery?
 Ever had surgery?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

DATE OF LAST:

Less than 6 mos.	6-18 mos.	Over 18 mos.	Never
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- Spinal examination
 Physical examination
 Blood test
 Chest x-ray
 Spinal x-ray
 Dental x-ray
 Urine test

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS

- Alcohol
 Coffee
 Tobacco
 Drugs
 Exercise
 Sleep
 Appetite

Heavy	Moderate	Light	None
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign Your Name _____ Date _____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202



ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

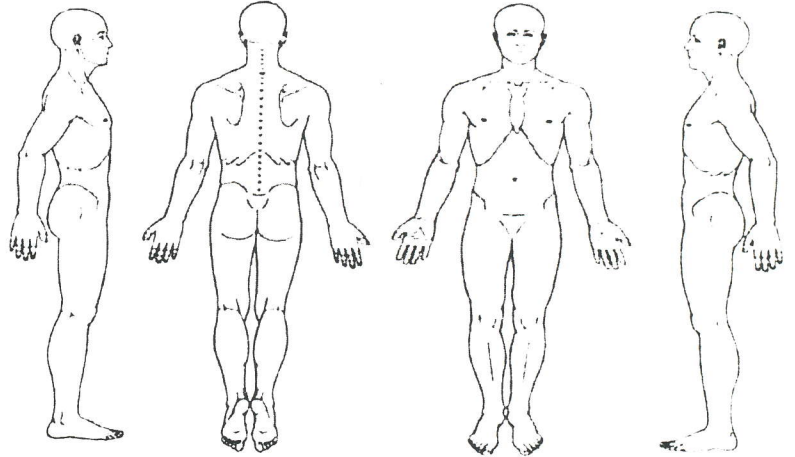
1. Describe your symptoms _____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



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



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)

- 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 ③ Medical Doctor ⑤ Other
- ② Chiropractor ④ Physical Therapist

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 ③ Medical Doctor ⑤ Other
- ② Chiropractor ④ Physical Therapist

10. What is your occupation?

- ① Professional/Executive ④ Laborer ⑦ Retired
- ② White Collar/Secretarial ⑤ Homemaker ⑧ Other
- ③ Tradesperson ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time ③ Self-employed ⑤ Off work
- ② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ Date _____