New Patient Intake Form

Welcome to our chiropractic office. We want to provide you with the best possible care. We base our care on a thorough history and examination. Thank you for taking the time to fill in our ***Patient Intake Form***. Please fill this form out as most complete as you can and to the best of your knowledge. Let our staff know if you have any questions. When completed return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Patient Name:_____ DOB:_____ Sex: M / F Referred by?_____

Address: _____ Email:_____

_____ Cell/Home #:_____

Office Policies

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature: _____ Date: _____

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 _____

_____

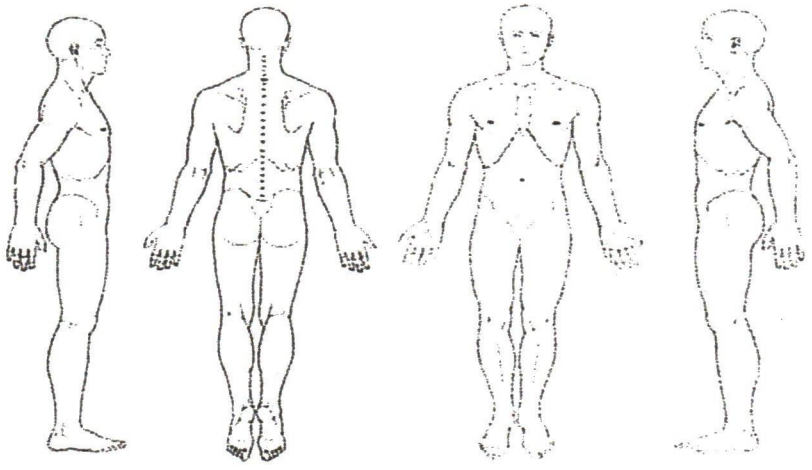
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ 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)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ 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)

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

7. In general would you say your overall health right now is...

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. Who have you seen for your symptoms?

☐ No One ☐ Medical Doctor ☐ Other
☐ Chiropractor ☐ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

9. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Medical Doctor ☐ Other
☐ Chiropractor ☐ Physical Therapist

10. What is your occupation?

_____

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

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

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

Physican Signature _____ **Date** _____

Humboldt Spine and Rehab PC

Patient Name:_____ Date:_____

The following information may be contributing to/complicating your current condition so please answer to the best of your ability:

Circle All That Apply

Social History

On average I consume:

A. Caffeine: Daily .. Occasionally .. Never
B. Alcohol: Daily .. Occasionally .. Former .. Never
C. Tobacco: Daily .. Occasionally .. Former .. Never

Review of Systems:

I have had or been told I have:

A. Epilepsy, Convulsions, Paralysis, Dementia, Alzheimer's, Migraine/Headaches or other disorders of the brain/nervous system.
B. Chest pain, Heart attack, Heart murmur, High/Low blood pressure, Palpitation, Stroke or other disorders of the circulatory system.
C. Asthma, Emphysema, Tuberculosis, Sleep apnea or other disorders of the respiratory system.
D. Allergies, Itching, Wheezing, Tonsillitis, Nose bleeds, Difficulty swallowing, Earaches, Sinusitis, Deafness, Double vision or other disorders of the eyes/ears/nose/throat.
E. Ulcer, Intestinal bleeding, Colitis, Constipation, Diarrhea, Hernia, Hepatitis or other disorders of the intestines/liver/pancreas/spleen.
F. Painful urination, Blood in urine, Increase/Decrease urination, Kidney stones, Nephritis, or other disorders of the bladder/kidneys.
G. Diabetes, Thyroid dysfunction or other glandular disorders.
H. Arthritis, Gout or other muscle/joint disorders.
I. Depression, Anxiety or other mental/emotional disorders.
J. Cancer, Tumor or Lymph node enlargement.
K. Physical deformity or defect.
L. *Any conditions/symptoms/disorders not listed above that you would like the doctor to know?*

Family History

Do you have parents, siblings or children that have been diagnosed with:

Cancer .. Diabetes .. Hypertension .. Heart Problems .. Kidney Problems .. Arthritis .. Osteoporosis .. Headache/Migraine .. Autoimmune Disorders

Personal History

List current medication: _____

(name, amounts, frequency, length of use, reason for use)

Brief Explanation:

Hospitalizations/ Surgeries: _____

Other Accidents/ Incidents: _____