

**Chiropractic Plus Pain to Wellness Center, PLLC**  
**Confidential Health History Form**

**For Office Use Only  
ID #**

**WELCOME!**

**PLEASE PRESENT INSURANCE CARDS & IDENTIFICATION TO COPY FOR FILES.**

**PATIENT INFORMATION PLEASE PRINT CLEARLY. THANK YOU!**

Name: \_\_\_\_\_  
Last First MI

If Minor, Name of Parent or Guardian: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street / Apt City State Zip

Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Email: \_\_\_\_\_ Is this the first visit to our office? \_\_\_ Yes \_\_\_ No

Gender: \_\_\_ Female \_\_\_ Male \_\_\_ Trans( \_\_\_ MTF/\_\_\_ FTM) Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Age: \_\_\_

Your Height: \_\_\_\_\_ Your Weight \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Domestic Partner \_\_\_ Divorced \_\_\_ Widowed

Spouse/Partner Name \_\_\_\_\_  
Last First MI

Names / Ages of Children \_\_\_\_\_

Females: Are you pregnant? \_\_\_ Yes \_\_\_ No If Pregnant, Due Date: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR OFFICE?** \_\_\_\_\_

**YOUR EMPLOYMENT INFORMATION:** Employer: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Address \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**ACCIDENT INFORMATION:** Is condition due to an accident? \_\_\_ Yes- Date of Accident \_\_\_\_\_ / \_\_\_ No  
Type of accident: \_\_\_ Auto \_\_\_ Work \_\_\_ Home Other \_\_\_\_\_

Did you report your accident to: \_\_\_ Auto Insurance Co. \_\_\_ Employer \_\_\_ Lawyer Other \_\_\_\_\_

Name of Attorney (if applicable) \_\_\_\_\_

**INSURANCE INFORMATION:**

Are you the Primary Insurance holder? \_\_\_ Yes \_\_\_ No If not, please complete the information below.

Policy Holder / Responsible Party If Not You: \_\_\_\_\_

Policy Holder's Relationship to you: \_\_\_\_\_ His or Her Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_

His or Her Address: \_\_\_\_\_  
Street City State Zip

***SIGNATURE(S) REQUIRED ON ALL FORMS. THANK YOU.***

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**IF MINOR, PARENT OR GUARDIAN NAME LISTED ABOVE  
SIGNATURE & CONSENT TO EXAMINE/TREAT MINOR** \_\_\_\_\_

# Patient Health Questionnaire - PHQ

Form PHQ-202

Health Plan Use Only rev 7/18/05

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

\_\_\_\_\_

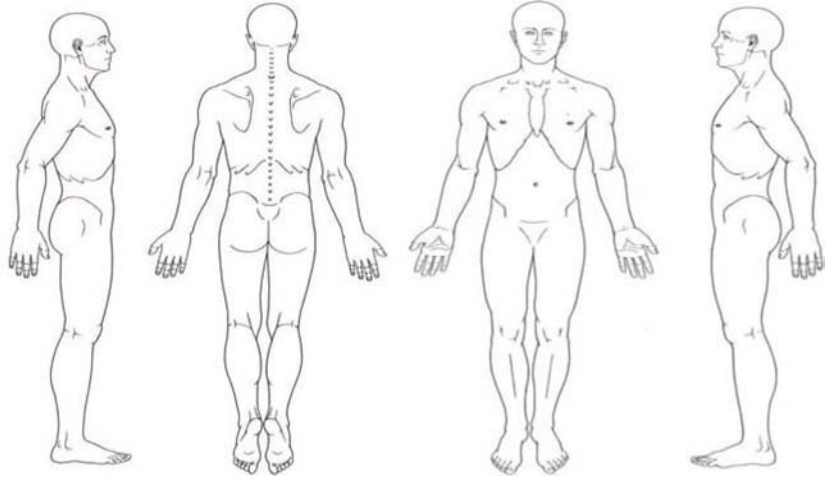
\_\_\_\_\_

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
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- 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

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable ⑩

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)Plan

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

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: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

- ① Yes
- ② No
- ③ This Office
- ④ Chiropractor
- ⑤ Medical Doctor
- ⑥ Physical Therapist
- ⑦ Other

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

## 10. What is your occupation?

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

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

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Confidential Health History Form**  
MEDICATIONS / VITAMINS / SURGERIES / ACCIDENTS/ ETC

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**ID #**

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

The following family members have the same or a similar problem as I do:  
\_\_\_ Mother \_\_\_ Father \_\_\_ Brother \_\_\_ Sister \_\_\_ Spouse \_\_\_ Child

What have you done for this condition? Was it of benefit? \_\_\_\_\_

What worsens your condition? \_\_\_\_\_

What activities would you like to do that you cannot because of your pain, illness, condition? (examples: pick up children, walk, sports) \_\_\_\_\_

PLEASE CHECK the desired type of care so that we may honor your healthcare goals:

\_\_\_ **RELIEF CARE:** Necessary to rid you of pain and symptoms, but usually not the full cause of pain and symptoms.

\_\_\_ **CORRECTIVE CARE:** More lasting than relief care. The goal of corrective care is to help you feel better longer with fewer to no recurrences of pain and symptoms. If recurrence occurs because of permanent components to your condition, the episodes are typically less frequent, less intense, and of shorter duration because optimal strength, flexibility, and function is restored.

\_\_\_ **PREVENTIVE / WELLNESS CARE:** I feel great and want to do all I can to stay that way!

**BIOCHEMICAL HEALTH / CURRENT MEDICATIONS & NUTRITIONAL SUPPLEMENTS (Continue other side if needed)**

Please list ALL **DRUGS** you currently take or have taken in the past 6 months:

Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ For what? \_\_\_\_\_

Please list all **NUTRITIONAL SUPPLEMENTS, VITAMINS, HOMEOPATHIC REMEDIES** you presently take:

Name \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ For what? \_\_\_\_\_

Name \_\_\_\_\_ For what? \_\_\_\_\_

**PRIMARY PHYSICIAN:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**CITY/STATE:** \_\_\_\_\_

**PHYSICAL HEALTH (Continue other side if needed)**

Please list all **SURGERIES** you have had

1. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

2. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

3. Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Please list any **ACCIDENTS AND INJURIES:** auto, work related, sports, other (especially if related to current condition).

1. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? \_\_\_ Yes \_\_\_ No

2. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? \_\_\_ Yes \_\_\_ No

3. Type \_\_\_\_\_ When \_\_\_\_\_ Hospitalized? \_\_\_ Yes \_\_\_ No

**How do you grade your physical health?** \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_ Getting better \_\_\_ Getting Worse

**Compared to 5 years ago, you are not:** \_\_\_ Not As Healthy \_\_\_ As Healthy \_\_\_ Healthier

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Confidential Health History Form**  
CONDITIONS & DISEASES / HABITS / RECENT EXAMS

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**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Are you interested in knowing more about which foods & supplements can help your overall health & well-being?  
\_\_\_ Yes \_\_\_ No \_\_\_ Maybe

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**  
\_\_\_ Anemia \_\_\_ Arthritis \_\_\_ Cancer \_\_\_ Chicken Pox \_\_\_ Convulsions/Seizures \_\_\_ Diabetes  
\_\_\_ Eczema \_\_\_ Epilepsy \_\_\_ Heart Disease \_\_\_ High Blood Pressure \_\_\_ Influenza \_\_\_ Lumbago  
\_\_\_ Measles \_\_\_ Mental Disorders \_\_\_ Mumps \_\_\_ Pleurisy \_\_\_ Pneumonia \_\_\_ Polio  
\_\_\_ Rheumatic Fever \_\_\_ Small Pox \_\_\_ Thyroid \_\_\_ Tuberculosis \_\_\_ Whooping Cough

**Have you been tested HIV positive?** \_\_\_ Yes \_\_\_ No

**CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST SIX (6) MONTHS:**

**MUSCULO-SKELETAL CODE:**  
\_\_\_ Low Back Pain  
\_\_\_ Pain Between Shoulders  
\_\_\_ Neck Pain  
\_\_\_ Arm Pain  
\_\_\_ Joint Pain / Stiffness  
\_\_\_ Walking Problems  
\_\_\_ Difficulty Chewing /  
Clicking Jaw  
\_\_\_ General Stiffness

**NERVOUS SYSTEM CODE:**  
\_\_\_ Nervous  
\_\_\_ Numbness  
\_\_\_ Paralysis  
\_\_\_ Dizziness  
\_\_\_ Forgetfulness  
\_\_\_ Confusion / Depression  
\_\_\_ Fainting  
\_\_\_ Convulsions  
\_\_\_ Cold/Tingling Extremities  
\_\_\_ Stress

**GENERAL CODE:**  
\_\_\_ Fatigue  
\_\_\_ Allergies  
\_\_\_ Loss of Sleep  
\_\_\_ Fever  
\_\_\_ Headaches

**GASTRO-INTESTINAL CODE:**  
\_\_\_ Poor / Excessive Appetite  
\_\_\_ Excessive Thirst  
\_\_\_ Frequent Nausea  
\_\_\_ Vomiting  
\_\_\_ Diarrhea  
\_\_\_ Constipation  
\_\_\_ Hemorrhoids  
\_\_\_ Liver Problems  
\_\_\_ Gall Bladder Problems  
\_\_\_ Weight Trouble  
\_\_\_ Abdominal Cramps

**GENITO-URINARY CODE:**  
\_\_\_ Bladder Trouble  
\_\_\_ Painful / Excessive Urination  
\_\_\_ Discolored Urine

**C-V-R CODE:**  
\_\_\_ Chest Pain  
\_\_\_ Short Breath  
\_\_\_ Blood Pressure Problems  
\_\_\_ Irregular Heartbeat  
\_\_\_ Heart Problems  
\_\_\_ Lung Problems / Congestion  
\_\_\_ Varicose Veins  
\_\_\_ Ankle Swelling  
\_\_\_ Stroke

**FEMALES ONLY:**  
When was your last period? \_\_\_\_\_  
Are you pregnant?  
\_\_\_ Yes \_\_\_ No \_\_\_ Not Sure

**MALE / FEMALE CODE:**  
\_\_\_ Menstrual Irregularity  
\_\_\_ Menstrual Cramps  
\_\_\_ Vaginal Pain / Infection  
\_\_\_ Breast Pain / Lumps  
\_\_\_ Prostate/Sexual Dysfunction  
\_\_\_ Other Problems

**EENT CODE:**  
\_\_\_ Vision Problems  
\_\_\_ Dental Problems  
\_\_\_ Sore Throat  
\_\_\_ Ear Aches  
\_\_\_ Hearing Difficulty  
\_\_\_ Stuffed Nose

**FAMILY HISTORY:**  
The following members have a same or similar problem as I do:  
\_\_\_ Mother  
\_\_\_ Father  
\_\_\_ Sister  
\_\_\_ Brother  
\_\_\_ Spouse  
\_\_\_ Child

**EXERCISE:** \_\_\_ None \_\_\_ Moderate \_\_\_ Heavy \_\_\_ Days/Week  
**WORK ACTIVITY:** \_\_\_ Sitting \_\_\_ Standing \_\_\_ Light Labor \_\_\_ Heavy Labor  
**HABITS:** \_\_\_ Coffee/Caffeine Drinks: \_\_\_ Cups / Day  
\_\_\_ Smoking: \_\_\_ Packs / day \_\_\_ Alcohol: \_\_\_ Drinks / week  
\_\_\_ High Stress: Reason \_\_\_\_\_

**DATE OF LAST:**  
Physical Exam \_\_\_\_\_  
Spinal Exam \_\_\_\_\_  
Blood Test \_\_\_\_\_  
Urine Test \_\_\_\_\_  
Spinal X-Ray \_\_\_\_\_  
Chest X-Ray \_\_\_\_\_

**Patient/Guardian Signature** \_\_\_\_\_  
**Date** \_\_\_\_\_