

# Chiropractic Care Center

1881 N Pontiac Trail Suite B Walled Lake, MI 48390 248-926-0455

## Patient Information

## Phone Numbers

Date \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_  
E-mail \_\_\_\_\_  
Sex M F Age \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Married Widowed Single  
Minor Separated Divorced  
Partnered for \_\_\_\_\_ years  
Occupation \_\_\_\_\_  
Patient Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT**  
Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Insurance Information

Who is responsible for this account \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance? Y N  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

## Accident Information

Is this condition due to an accident? Y N  
Date \_\_\_\_\_  
Type of accident Auto Work Home Other  
To whom have you made a reported it to?  
Auto Insurance Employer Workers comp.  
Other \_\_\_\_\_

# Patient Health Questionnaire

American Chiropractic Network



ACN Use Only rev 4/23/99

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

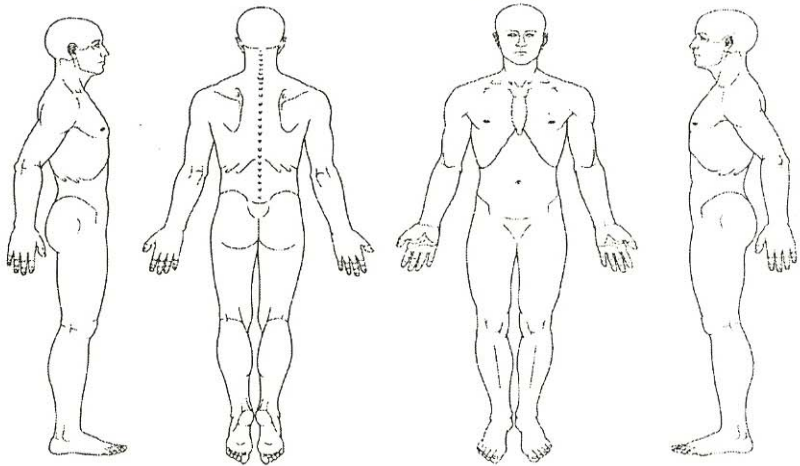
Date \_\_\_\_\_

1. When did your symptoms start: \_\_\_\_\_

Describe your symptoms and how they began:

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. How bad are your symptoms at their:

- None Unbearable
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints      ② Mild, forgotten with activity      ③ Moderate, interferes with activity      ④ Limiting, prevents full activity      ⑤ Intense, preoccupied with seeking relief      ⑥ Severe, no activity possible

7. What activities make your symptoms worse: \_\_\_\_\_

8. What activities make your symptoms better: \_\_\_\_\_

9. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment? \_\_\_\_\_

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: \_\_\_\_\_

10. 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
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. 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

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

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

Date \_\_\_\_\_

