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:*

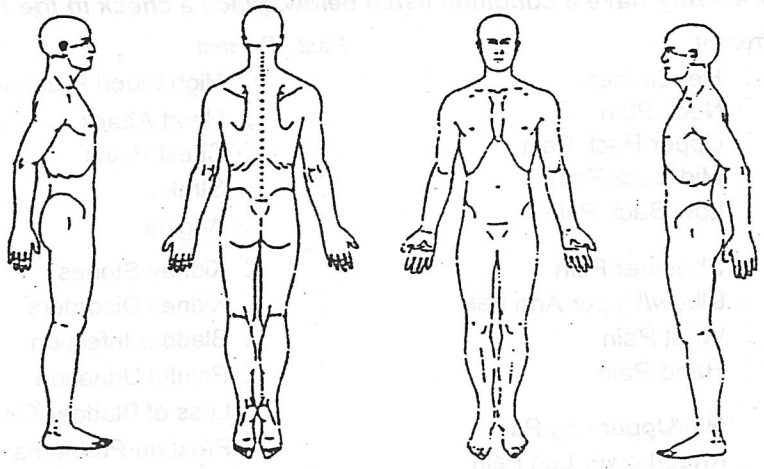
_____

_____

2. How often do you experience your symptoms?

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)

Indicate where you have pain or other symptoms



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. How bad are your symptoms at their:

	None									Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

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

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*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:* _____ ③ CT Scan *date:* _____
② MRI *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* _____

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What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ] Feet [ ][ ] Inches Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Use Tobacco Products
						☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain				☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite	*Females Only*		
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			
			☐	☐	Ulcer	☐	☐	Birth Control Pills
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis						
			☐	☐	Cancer	*Other Health Problems/Issues*		
☐	☐	General Fatigue	☐	☐	Tumor			
☐	☐	Muscular Incoordination				☐	☐	
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	
☐	☐	Dizziness	☐	☐	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ *Date* _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ *Date* _____

Barry Road Chiropractic

Name (First)_____(Middle Init)____(Last)_____

Date_____ Gender: M / F Home Phone_____

Cell #_____Work #_____

Address _____

City_____State_____Zip_____

If you would like to receive correspondence by e-mail instead of by mail,

please supply your email address_____

D.O.B._____SSN_____Employer_____

Primary Care Physician/Clinic _____

Is your pain a result of an **accident** or **workmen's comp** case? **Y / N** If so, please tell the receptionist.

How did you learn about this clinic _____

Spouse's Name_____Guardian's Name_____

If insurance is through a spouse or guardian, please provide us with their following information:

Employer_____D.O.B._____SSN_____

I authorize the doctor(s) to perform such diagnostic procedures & to administer whatever treatment is necessary to treat my present problem or illness. I understand & accept that I am responsible for all charges notwithstanding denial, reduction of benefit or failure to pay on the part of my insurance company. I authorize any information concerning my health & services rendered to be released to my insurance company and/or attorney. I understand that my private information will not be shared with anyone else without my permission in writing. I authorize that insurance payment for my services are paid directly to Barry Road Chiropractic.

1. If you have an HMO, POS, or PPO insurance requiring a referral, **you must have a completed referral form or number with you at the time of your appointment** or we cannot see you. (This is your insurance company's policy, not ours.)
2. **Fees, copays, and deductibles are due and payable at the time of your appointment**. We accept cash, checks, charge and debit. As a service to our patients we will prepare and file both primary and secondary insurances provided that we have current identifying information.
3. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party in that contract. In the case of managed health care (PPO/POS/HMO), we have a separate contract between the doctor and the insurance company.
4. We understand that temporary financial problems may affect timely payment of your balance. If a patient is unable to afford payment at the time of service we will consider your account in good standing if **10%** of the **total bill is paid each month**. If a patient's account has not been in good standing for more than 90 days we reserve the right to add a 30% finance charge and send the account to a collection agency. Interest charges may also apply on delinquent accounts. Please contact our office before you are sent to collections if you are having trouble making payments. Once the collection agency is involved, we cannot remove their fee.
5. Disability/Additional Insurance Forms – We will be happy to complete your disability/additional insurance forms for a $25.00 charge due at the time of service.

I hereby acknowledge that I have read, understand & agree to the terms of this document relating to insurance coverage & payment of my bill.

_____ _____

Patient's or Guardian's Signature Date