

Confidential Patient Health Record

DATE: _____

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F

Social Security: _____ Driver's License Number: _____

Circle One: Married Single Widowed Divorced Separated E-mail: _____

Business Employer: _____

Business Phone: _____ Type of Work: _____

Name of Spouse (Parent): _____ Spouse's (Parent) Social Security #: _____

Spouse's (Parent) Employer: _____ Business Phone: _____

Type of Work: _____ Ages of Children _____

How Did You Hear About Our Office? _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare

Personal Health Insurance (Name) _____ Health Card # _____

Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: Yes No _Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: Yes No

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine

Insulin Other _____

Do You Wear A Shoe Lift? Yes No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: Pacemaker Appendectomy Tonsillectomy Gall Bladder

Hernia Back Surgery Broken Bones Other _____

Major Accident or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However these questions must be answered carefully as these problems can affect your overall course of care.

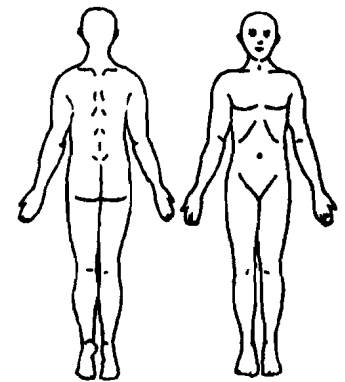
CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ALS | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Influenza | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Thyroid hyper / hypo |
| <input type="checkbox"/> Cancer:
Type: _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Lupus | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | INTAKE |
| <input type="checkbox"/> Diabetes insulin dependent
non-insulin dependent | <input type="checkbox"/> Mental Disorders
Type: _____ | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Caffeinated Beverages |
| <input type="checkbox"/> MS | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Alcohol: Amt _____ day /wk/ mo |
| | | | <input type="checkbox"/> Cigarettes: Amt _____ |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Appetite | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Vaginal Pain/Infection |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Lung Problems/Congestion | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Black/Bloody Stool _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Breast Pain/Lumps | <input type="checkbox"/> Fever | <input type="checkbox"/> Nervous | <input type="checkbox"/> Other Problems:

_____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Numbness | |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Pain Between Shoulders | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Painful Urination | |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Gas/Bloating After Meals | <input type="checkbox"/> Paralysis | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Poor Appetite | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headaches | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Sexual Dysfunction | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Stress | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Short Breath | |
| <input type="checkbox"/> Difficult Chewing/
Clicking Jaw | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sore Throat | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stuffed Nose | |
| | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Tingling Extremities | |
| | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Unexplained Weight Gain | |



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

Place an (X) if any family members has suffered from:

- | | | |
|--|---|----------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer | who _____ type _____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Diabetes | who _____ type _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | who _____ |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> MS | <input type="checkbox"/> Migraines | who _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Spinal Disorder | who _____ type _____ |
| | <input type="checkbox"/> Other, list _____ | |

FEMALES ONLY

When was your last period?

Are you on oral contraceptives?
 Yes No

Are you pregnant?
 Yes No Not Sure

Patient (Parent) Signature: _____ Date: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

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

Patient Name _____ Date _____

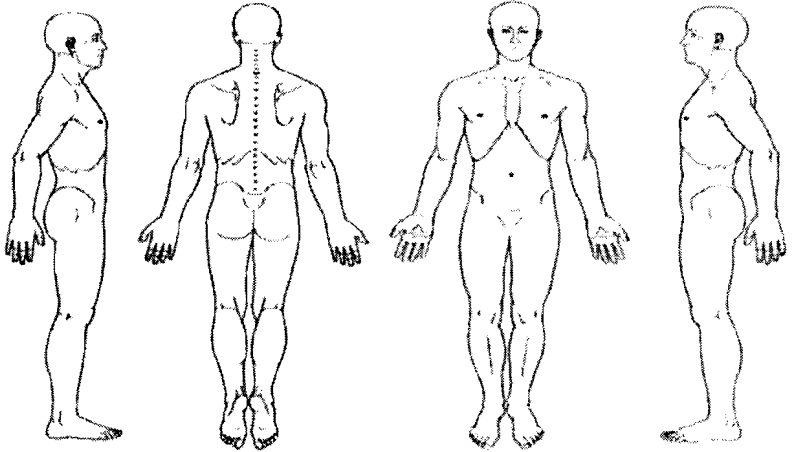
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? 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)

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

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

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

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 _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Neck
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Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name

Date

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓩ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓩ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓩ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓩ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓩ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓩ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓩ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓩ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓩ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓩ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

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Score