Confidential Patient Information

Date: _____

Last Name: _____ **First**: _____ **MI**: _____

Address: _____

City: _____ **State:** _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **E-Mail:** _____

Age: _____ **Date of Birth** _____ **Sex:** _____ **SSN#:** _____

Marital Status: S M W D **Spouses Name:** _____

Who referred you to our office? _____

Employer: _____ **Occupation:** _____

Employer Address: _____ **Phone:** _____

City: _____ **State**: _____ **Zip**: _____

Insurance Carrier: _____ **Phone:** _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Policy Number: _____ **Group Number:** _____

Have you suffered from any of the following?

	Yes	No		Yes	No
Dizziness			Asthma		
Backaches			Neuritis		
Heart Trouble			Digestive Disorders		
Diabetes			Nervousness		
Tuberculosis			Sinus Trouble		
Arthritis			Cancer		
Headaches			Anemia		
Recent Infection			Recent Fever		
HIV / Aids			High Blood Pressure		
Stroke			Numbness and Tingling		
Urinary Retention			Aneurysm		
Frequent Urination			Osteoporosis		
Recent Trauma			Prostate Problems		
Weight gain			Epilepsy / Seizures		
Weight Loss			Visual Disturbances		
Alcohol Use			Tobacco Use		

Surgeries:

Hospitalization:

Medication:

Patient Health Questionnaire

Patient Name: _____ Date: _____

Describe your symptoms: _____

_____

_____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

	Constant	**76-100% of the day**
	Frequently	**51-75% of the day**
	Occasionally	**26-50% of the day**
	Intermittently	**0-25% of the day**

What describes the nature of your symptoms?

	Sharp		**Shooting**
	Dull		**Achy**
	Numb		**Tingling**
	Throbbing		**Burning**

How are your symptoms changing?

	Getting Worse
	Not Changing
	Getting Better

During the past 4 weeks indicate the average intensity of your symptoms

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Minimal Unbearable

How much has pain interfered with your normal work (Including both work and outside home and house work)
1) Not at all 2) A little bit 3) Moderately 4) Quite a bit 5) Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities?
1) All of the time 2) Most of the time 3) Some of the time 4) A little bit of the time 5) None of the time

In general how would you say your overall health is right now?
1) Excellent 2) Very Good 3) Good 4) Fair 5) Poor

Who else have you seen for your Symptoms? _____

What treatment did your receive and when? _____

What tests have you had for your problem and when were they performed: X-rays MRI CT Scan Other

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that the representatives of Ace Plaza Chiropractic will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized should be paid directly to Ace Plaza Chiropractic, and that amount will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ Date:_____