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Chiropractic HEALTH & WELLNESS CENTER

Patient Information

Todays Date: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female ❑ Declined to Specify SSN: _____

First Name: _____ Middle Name: _____ Last Name: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Immediate Family Seen by CHWC _____

Emergency Contact: _____

Relation: _____ Phone: _____

Referred By: _____

Employer Information

Occupation: _____ Status: ❑ Full-Time ❑ Part-Time ❑ Student ❑ Homemaker ❑ Retired ❑ Unemployed

Employer or School: _____ Phone: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Carrier: _____ Phone: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Sex: ❑ M ❑ F Date of Birth: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Relation to Patient: _____ Phone: _____

Secondary Insurance Carrier: _____ Phone: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Sex: ❑ M ❑ F Date of Birth: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Relation to Patient: _____ Phone: _____

Patient Health History Questionnaire

Patient Name: _____ **DOB**:_____

List all Prescription, Over-the-Counter medications, and Nutritional/Herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

*List any **Medication Allergies**:* _____

List all the Surgical Procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

What type of regular exercise do you perform? ❑ None ❑ Light ❑ Moderate ❑ Strenuous

What is your height and weight? Height _____ 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	❑	❑	Drug Alcohol Dependence
❑	❑	Low Back Pain	❑	❑	Angina	❑	❑	Smoking/Nicotine Products
❑	❑	Shoulder pain	❑	❑	Kidney Stones	❑	❑	Allergies
❑	❑	Elbow/Upper Arm Pain	❑	❑	Kidney Disorders	❑	❑	Depression
❑	❑	Wrist pain	❑	❑	Bladder Infection	❑	❑	Systemic Lupus
❑	❑	Hand Pain	❑	❑	Painful Urination	❑	❑	Epilepsy
❑	❑	Hip/Upper Leg pain	❑	❑	Loss of Bladder Control	❑	❑	Dermatitis/Eczema/Rash
❑	❑	Knee/Lower Leg Pain	❑	❑	Prostate Problems	❑	❑	HIV/AIDS
❑	❑	Ankle/Foot Pain	❑	❑	Abnormal Weight Gain/Loss	❑	❑	SARS Covid 19
❑	❑	Jaw Pain	❑	❑	Loss of Appetite	❑	❑	Chronic Sinusitis
❑	❑	Joint Swelling/Stiffness	❑	❑	Abdominal Pain	❑	❑	Other_____
❑	❑	Arthritis	❑	❑	Ulcer	❑	❑	Other_____
❑	❑	Rheumatoid Arthritis	❑	❑	Hepatitis			
❑	❑	General Fatigue	❑	❑	Liver/Gall Bladder Disorder			***Females Only***
❑	❑	Muscular Incoordination	❑	❑	Cancer	❑	❑	Birth Control Pills
❑	❑	Visual Disturbances	❑	❑	Tumor	❑	❑	Hormonal Replacement
❑	❑	Dizziness	❑	❑	Asthma	❑	❑	Pregnancy

Patient Social

Alcohol	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never	Caffeine	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never
Diet Food	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never	Drugs	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never
Stimulants	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never	Exercise	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never
Homemade Food	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never	Processed Food	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never
Soft Drinks	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never	Tobacco	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never
Water	❑ Daily	❑ Weekly	❑ Occasionally	❑ Never					

Smoking: ❑ Every Day Smoker ❑ Occasional Smoker ❑ Former Smoker ❑ Never Smoked

Race: ❑ American Indian or Alaska Native ❑ Black or African American ❑ Asian

❑ White (Caucasian) ❑ Native Hawaiian or Pacific Islander ❑ Declined to Answer

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to Answer

Patient Health Questionnaire

Patient Name _____ ***DOB*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

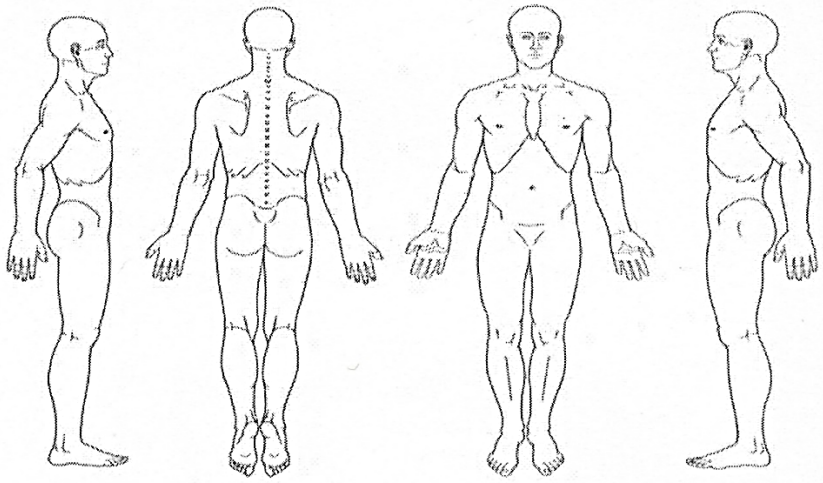
_____

_____

2. How often do you experience your symptoms?

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ❑ Sharp ❑ Shooting
- ❑ Dull ache ❑ Burning
- ❑ Numb ❑ Tingling

4. How are your symptoms changing?

- ❑ Getting Better
- ❑ Not Changing
- ❑ 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?

- ❑ No One
- ❑ Other Chiropractor
- ❑ Medical Doctor
- ❑ Physical Therapist
- ❑ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

- ❑ Xrays *date:* _____
- ❑ CT Scan *date:* _____
- ❑ MRI *date:* _____
- ❑ Other *date:* _____

10. Have you had similar symptoms in the past? ❑ Yes ❑ No

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

- ❑ This Office
- ❑ Other Chiropractor
- ❑ Medical Doctor
- ❑ Physical Therapist
- ❑ Other

11. What is your occupation?

_____

- ❑ Professional/Executive
- ❑ White Collar/Secretarial
- ❑ Tradesperson
- ❑ Laborer
- ❑ Homemaker
- ❑ FT Student
- ❑ Retired
- ❑ Other

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

- ❑ Full-time
- ❑ Part-time
- ❑ Self-employed
- ❑ Unemployed
- ❑ Off work
- ❑ Other

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

- ❑ Reduce symptoms
- ❑ Resume/increase activity
- ❑ Explanation of condition/treatment
- ❑ Learn how to take care of this on my own
- ❑ How to prevent this from occurring again

Patient Signature _____ ***Date*** _____