PATIENT HEALTH QUESTIONNAIRE

PERSONAL INFORMATION

Today's Date: _____ File #:_____

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

Preferred First Name / Nickname: _____ Social Security #:_____-_____-_____

Are you: ❒ right handed ❒ left handed ❒ ambidextrous Date of Birth: _____/_____/_____ Age: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home: _____- _____-_____ Work: _____- _____-_____ ext._____ OK to call at work? ❒ Yes ❒ No

Cell: _____- _____-_____ Email Address_____

Marital Status: S M D W Name of Spouse: _____ _____

Ages & Names of Children: _____

Occupation: _____ Employer: _____

Business Address: _____

Who Referred You To Our Offic e Or How Did You Hear About Us? _____

Have You Had Previous C hiropractic Care? ❒ No ❒ Yes; if so please indicate when and the doctors name: _____

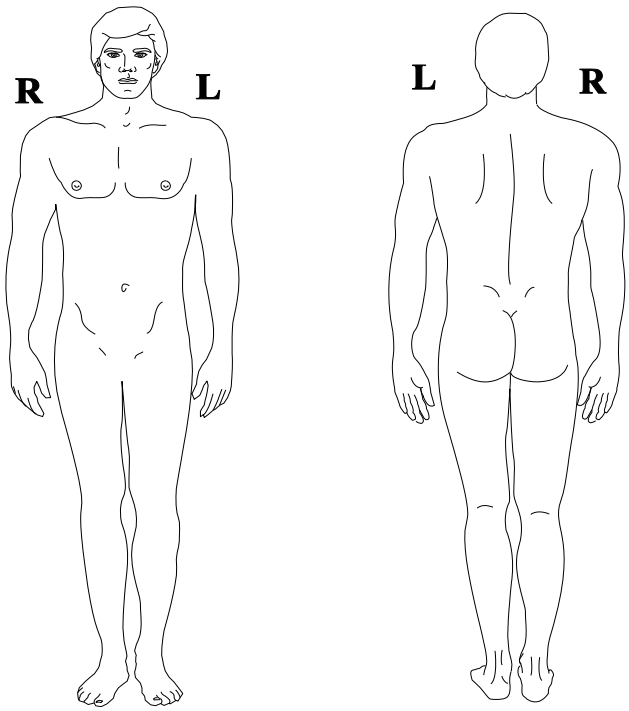
_____

Primary Care Doctor: _____ Your Last Physical Examination: ____/____/____

Emergency Contact_____ Phone: _____- _____-_____

CURRENT COMPLAINTS

Pain Drawing: Please mark where and what type of pain you are currently experiencing. Use the symbols indicated to describe the type of pain or sensations you are feeling:



Use these symbols to describe the type of pain or sensations you are feeling:

>>>	**Aching pain**
///	**Stabbing or Sharp pain**
XXX	**Burning pain**
===	**Numbness**
ooo	**Pins and Needles**

Please list your complaints below with the most significant or primary complaint first:

1. **Area of Pain**: _____ **Frequency**: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
   Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

   No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

   The pain is aggravated by: _____

   The pain is relieved by: _____

2. **Area of Pain**: _____ **Frequency**: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
   Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

   No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

   The pain is aggravated by: _____

   The pain is relieved by: _____

3. **Area of Pain**: _____ **Frequency**: ❒ intermittent ❒ occasional ❒ frequent ❒ constant
   Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

   No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

   The pain is aggravated by: _____

   The pain is relieved by: _____

4. Other: _____

_____

_____

In general my symptoms are worse in: ❒ AM ❒ Midday ❒ PM; ❒ my symptoms do not change with the time of day.

Are your symptoms / condition: ❒ improving ❒ unchanged ❒ getting worse

Do you wear orthotics? ❒ Yes ❒ No Are you interested in orthotics? ❒ Yes ❒ No

HISTORY

Symptoms developed from: ❒ work injury ❒ car accident ❒ sports injury ❒ lifting/fall ❒ gradual ❒ unknown

The pain began on or about: _____. The pain is chronic and originally began on or about: _____

Describe how the symptoms began or what you think caused the symptoms / condition: _____

_____

_____

_____

_____

List other doctors you have seen for this complaint, the type of treatment given, and the result of that treatment: _____

_____

_____

_____

Describe any past history of the same or similar complaint: _____

_____

_____

_____

MEDICAL HISTORY

CHECK HERE IF YOU HAVE HAD OR ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

❒ Blurring vision
❒ Dizziness
❒ Loss of bowel or bladder function
❒ Constipation
❒ Diarrhea
❒ Rectal bleeding
❒ Allergies
❒ Buzzing or ringing in ears
❒ Numbness
❒ Confusion
❒ Loss of sleep
❒ Stomach difficulty
❒ Frequent urination
❒ Frequent colds
❒ Asthma
❒ Headaches: Area of head:_____
How often: ❒ daily ❒ ____ times per day
❒ ____ times per week ❒ ____ times per month
❒ Chest pains
❒ Painful urination
❒ Difficulty swallowing
❒ Hay fever

Do you have a pacemaker? ❒ Yes ❒ No

Please list any serious illness or medical conditions you have had and associated treatment **:**

_____

_____

Please list ANY and ALL Medications you are t aking or currently prescribed**:**

_____

_____

Please list the name and address of your primary care physician & any specialist you have seen**:**

_____

_____

Women Only

Important - If you suspect you are currently pregnant, please notify the doctor immediately.
X-rays should not be taken if you are pregnant!

Are you pregnant? ❒ Yes ❒ No Date of last menstr ual cycle: _____

SURGICAL HISTORY

Please list any surgeries you have had; include date, type of surgery or for what condition and outcome:

_____

_____

FAMILY HISTORY

Please list any family history of heart disease, cancer, diabetes or other serious illness:

_____

_____

SOCIAL HISTORY

Do you smoke? ❒ No ❒ Yes If yes, how many p acks of cigarettes do you smoke per day? _____

How many cups of coffee or caffeinated drinks do you have per day? _____

Do you consume alcohol? ❒ No ❒ Yes If yes, would you say that your use of alcohol is ❒ occasional ❒ frequent or ❒ daily.

Do you have a regular program of exercise? ❒ No ❒ Yes If yes, please note the frequency and type of exercise that you do:

_____

List any hobbies or recreational sports / activities you enjoy doing:

_____

CERTIFICATION AND ASSIGNMENT

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

I hereby authorize the Doctor to examine and treat my conditions as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ (or guardian if child) **Date: _____/_____/_____**

Patient Information Usage Agreement

The 1996 HIPAA Legislation contains provisions that prohibit the disclosure of patient information; compliance "to the Letter" of the act would create a highly impersonal atmosphere and longer visit times in the office. Use of certain items of your personal information within the space of the office will help us preserve the family atmosphere and keep your visits on schedule.

In order to make my visits to the office as easy as possible, I agree to let Calvert Chiropractic doctors and staff use limited personal information for the following purposes:
(please check the "yes" box for all items that you agree to.)

Call me by name while in the office. Nickname? _____	☐ Yes	☐ No
Have a patient sign-in sheet that will be seen by other patients	☐ Yes	☐ No
Have a personal discussion with me in common areas of the office	☐ Yes	☐ No
Call me regarding appointments at the telephone number(s) listed in my records	☐ Yes	☐ No
Send text message or email reminding you of your upcoming appointments **If yes for text message reminder, who is your cell phone carrier_____ ____**	☐ Yes	☐ No
Leave a message on an answering machine or with a family member regarding appointments, at the telephone number(s) listed in my records	☐ Yes	☐ No
Leave a message at my place(s) of employment, regarding appointments, at the telephone number(s) listed in my records	☐ Yes	☐ No
Call to request test results on my behalf from imaging centers, labs, or other referred specialists	☐ Yes	☐ No
I hereby release any hospital, physician, health care provider, or facility and authorize to furnish Calvert Chiropractic any and all information with respect to any illness, disease, or injury, history, or treatment and a copy of all records concerning the same. A photostat reproduction of this medical release authorization shall serve, for all purposes, the same as the original here of.	☐ Yes	☐ No

_____ _____ _____

Print Name **Signature** **Date**

Pleases supply alternate instructions for any of the items checked "no" in the following space

Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understan d both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily of the spine) and function (primarily of the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Chiropractic care, like all forms of health care, offers considerable benefit, but may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care and physical therapies include, but are not limited to the following:

Sprain/strain injuries
Irritation of a disc condition
Fractures
Burns
Stroke
Dislocations
Other injuries which relate to physi cal aberrations unknown or reasonably undetectable by the doctor

If you have any questions or concerns pertaining to the above, please feel free to talk with one of our Doctors.

A Chiropractic adjustment is the specific application of forces to correct an d/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments may be performed by hand and/or specific handheld instruments. In addition, ancillary procedures such as physiotherapy and/or reha bilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I understand and accept that there are risks associated with chiropractic care and physical therapy and give my consent to the examinations, Chiropractic care and Physical therapies that the doctor deems necessary, as reported following my assessment.

Print Name	**Signature**	**Date**