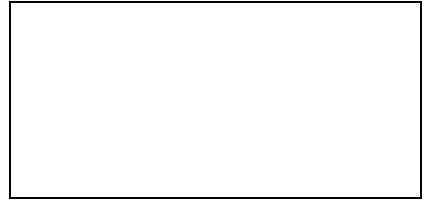


POUND FAMILY CHIROPRACTIC
PERSONAL INFORMATION



Name: _____ DOB: _____ Age: _____
 Last First Maiden

Address: _____
 Street City State Zip

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Social Security # _____

Married: Single: Number of Children: _____

Occupation: _____ Employer: _____ Work Phone: (____) _____ - _____

Spouse Name: _____ Soc.Sec.# _____ Spouse DOB: _____

Spouse Employer: _____ Spouse Employer Phone: (____) _____ - _____

Who is responsible for your bill? You You & Spouse Workers Comp
 Medicare Auto Insurance Personal Health Ins. Other _____

MEDICAL INFORMATION:

Are you Pregnant? Yes No

Have you ever been under chiropractic care before? Yes No Doctor's Name: _____

Have you been in any car accidents? Yes No If yes, give a brief description of each and the year it occurred:

Is your condition due to an injury or sickness arising out of your employment? Yes No

Have you had any falls in your lifetime? Yes No If yes, explain _____

Do you have a family physician? Yes No Dr.'s Name _____

Do you take any nutritional supplements? Yes No

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Do you exercise regularly? Yes No

OTHER INFORMATION:

How did you hear about our office? (please circle all that apply)

Newspaper *Yellow Pages* *Radio* *TV* *Other* *Patient* (Patients Name: _____)

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

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

Patient Name _____ Date _____

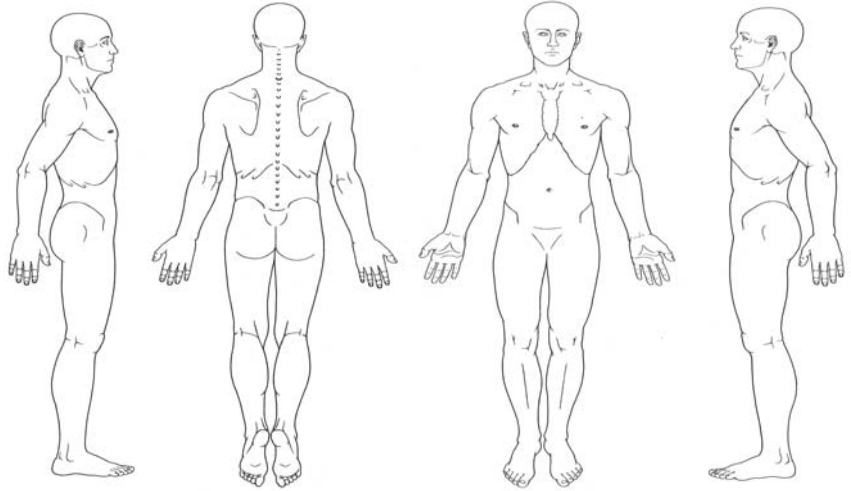
1. Describe your symptoms

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 ⑩ Unbearable

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 Other 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 Other 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 _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

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

Patient Name _____ Date _____

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

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

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
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Females Only

- Birth Control Pills
 Hormonal Replacement
 Pregnancy

Other Health Problems/Issues

-

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 _____