



PATIENT

Last Name: _____ First Name: _____ Middle Initial: _____
 Gender: M F Date of Birth: ___/___/___ Age: ___ SS#: _____ How many children? _____
 Address: _____ Apt #: _____
 City: _____ State: _____ Zip Code: _____
 Home Ph: (____) _____ Work Ph: (____) _____ Cell Ph: (____) _____
 Employer Name: _____ Occupation: _____
 City: _____ State: _____ Zip Code: _____

SPOUSE or GUARDIAN

Last Name: _____ First Name: _____ Middle Initial: _____
 Employer Name: _____ Work Phone: _____

EMERGENCY *(Name and address of the nearest relative or friend not living with you)*

Last Name: _____ First Name: _____ Middle Initial: _____
 Home Phone # (____) _____ Work Phone # (____) _____
 Relationship to Patient: _____

INSURANCE

Primary Insurance Company: _____
 Insured's Name: _____ Insured Date of Birth: ___/___/___
 Secondary Insurance Company: _____
 Insured's Name: _____ Insured Date of Birth: ___/___/___

PAYMENT METHOD: Cash Check Visa Mastercard Discover

RESPONSIBLE PARTY *(Complete this section if someone other than the patient is responsible for the bill.)*

Responsible Party: _____ Relationship to Patient: _____
 Address: _____ Apt #: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone # (____) _____ Work Phone # (____) _____
 Employer Name: _____ Occupation: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

Is this condition due to an injury arising out of employment? Yes No

Is this condition due to an injury arising out of an auto accident? Yes No

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Health Questionnaire

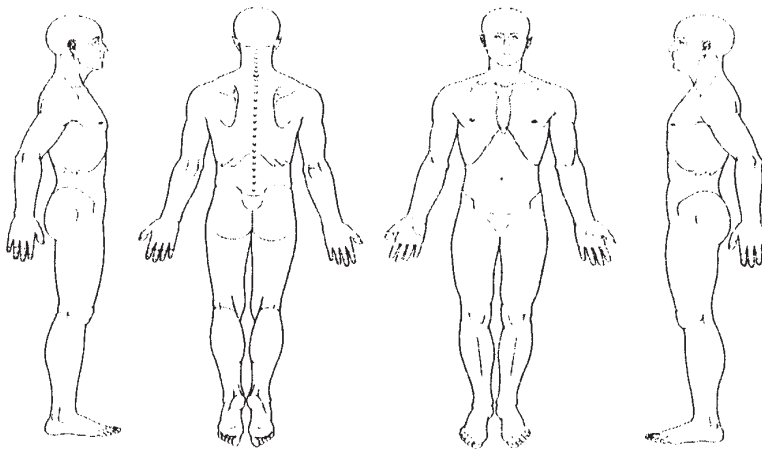
Patient Name: _____ **Date:** _____

1. Describe your symptoms and how they began: _____

2. Have you ever received chiropractic treatment for any condition in the past? Yes No

3. When did your symptoms start? _____

4. Indicate below on diagram where you have pain or other symptoms:



5. 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)

6. What describes the nature of your symptoms?

- Sharp
- Dull Ache
- Numb
- Shooting
- Burning
- Tingling

7. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

8. How bad are your symptoms

	No Pain											Unbearable
at their best:	0	1	2	3	4	5	6	7	8	9	10	
at their worst:	0	1	2	3	4	5	6	7	8	9	10	

