Patient Information

ACUCARE Total Health

❒New Patient ❒Update on Current Patient

Name _____ Today's Date _____
last first M.I.

Mailing Address _____
street city state zip

Home Phone _____/_____ Cell Phone _____/_____ Work Phone _____/ _____

Person to notify in case of emergency _____ Phone _____

Occupation _____ Employer _____ Phone# ____/_____

Date of Birth ____/____/_____ Marital Status: _____ Spouse/Significant Other_____

SS # _____-_____-_____

❒Male ❒Female How did you hear about our practice? Physician _____ Internet ____

Family _____ Friend_____

Primary Care Physician_____

Phone _____/_____ Fax _____/_____ Referred By_____

Guarantor

❒Self ❒Parent ❒Spouse ❒Responsible Party (if not patient, describe relationship to patient)_____

Name _____ Date of Birth ____/____/____
last first M.I.

Address _____
street city state zip

Home Phone _____/_____ Cell Phone _____/_____ Work Phone _____/ _____

Insurance Carrier Information

Primary Insurance _____

Primary Card Holder _____ D.O.B. ____/____/_____ SS# _____-____-_____

Secondary Insurance_____

Secondary Card Holder _____ D.O.B. ____/____/_____ SS # _____-____-_____

Auto/Worker's Comp/Personal Injury

❒Auto ❒Worker's Comp ❒Personal Injury

Date of Injury: ____/____/____ Claim # _____

Insurance Name & Address _____

Person in Charge of Case: _____ Phone # _____/_____

Patient/Guardian Signature _____ Date_____/_____/_____

If Guardian, relationship to patient _____

Patient Health Questionnaire

ACUCARE Total Health

Patient Name _____ **Date** _____

1. Describe your symptoms: _____

_____

When did your symptoms begin: _____

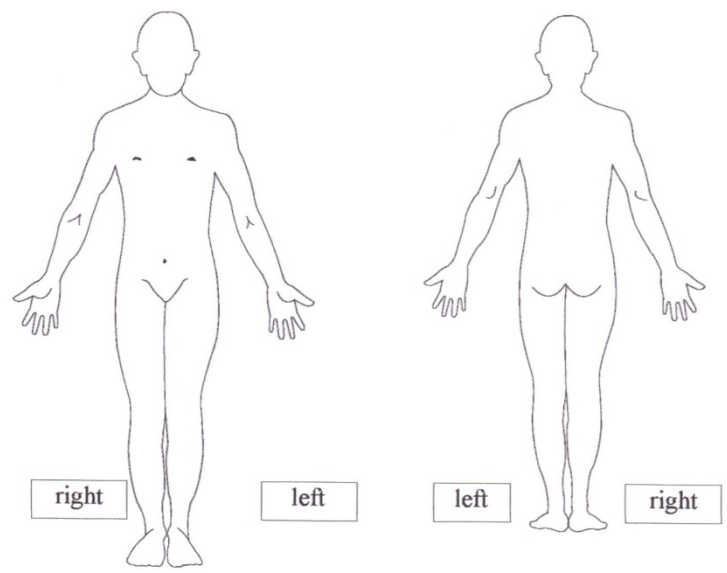
How did your symptoms start:_____

2. How often do you experience your symptoms?
Indicate where you have pain or other symptom.

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

3. What describes the nature of your symptoms?
Please indicate type of pain on the pictures →

- o Sharp (S)
- o Dull ache (D)
- o Numb (N)
- o Shooting (O)
- o Burning (B)
- o Tingling (T)



4. How are your symptoms changing?

- o Getting Better
- o Not Changing
- o Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None										**Unbearable**
0	1	2	3	4	5	6	7	8	9	10

b. How much has pain interfered with your normal work (including both work outside the home, and housework)
Not at all A little bit Moderately Quite a bit Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

All of the time Most of the time Some of the time A little of the time None of the time

7. In general would you say your overall health right now is…

Excellent Very Good Good Fair Poor

8. Who have you seen for your symptoms? No One Medical Doctor Other
Other Chiropractor Physical Therapist

a. What treatment did you receive and when?_____

b. What tests have you had for your symptoms and when were they performed? Xrays date:_____ CT Scan date:_____ MRI date: _____ Other date: _____

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

10. What is your occupation?_____ Professional/Executive Laborer Retired
White Collar/Secretarial Homemaker Other
Tradesperson FT Student

a. If you are not retired, a homemaker or a student, what is your current work status? Fulltime Self- employed Off Work
Part-time Unemployed Other

Patient Signature _____ **Date** _____

Health History

ACUCARE Total Health

What treatment have you already received for your condition?

Medication Surgery Physical Therapy Chiropractic Services None

Other_____

Name and address of other doctor(s) who have treated you for your condition:_____

_____

Date of last: Physical Exam_____ Spinal Exam_____ MRI/CT/bone scan_____

Spinal X-ray_____ Blood/Urine test_____

Mark with an X to indicate if you have/had any of the following. Please also mark any that apply to immediate family, and indicate the relationship to you.

( ) AIDS/HIV	( ) Goiter	( ) Pneumonia
( ) Alcoholism	( ) Gonorrhea	( ) Polio
( ) Allergy Shots	( ) Gout	( ) Prostate problems
( ) Anemia	( ) Heart Disease	( ) Prosthesis
( ) Anorexia	( ) Hepatitis	( ) Psychiatric Care
( ) Appendicitis	( ) Hernia	( ) Rheumatoid Arthritis
( ) Arthritis	( ) Herniated Disc	( ) Rheumatic Fever
( ) Asthma	( ) Herpes	( ) Scarlet Fever
( ) Bleeding disorders	( ) High Cholesterol	( ) Stroke
( ) Breast Lump	( ) Kidney Disease	( ) STD
( ) Bronchitis	( ) Liver Disease	( ) Suicide attempts
( ) Bulimia	( ) Measles	( ) Thyroid problem
( ) Cancer	( ) Migraines	( ) Tonsillitis
( ) Cataracts	( ) Miscarriage	( ) Tuberculosis
( ) Chemical dependency	( ) Mononucleosis	( ) Tumors
( ) Chicken Pox	( ) Multiple Sclerosis	( ) Typhoid Fever
( ) Diabetes	( ) Mumps	( ) Ulcers
( ) Emphysema	( ) Osteoporosis	( ) Vaginal Infections
( ) Epilepsy	( ) Pacemaker	( ) Whooping Cough
( ) Fractures	( ) Parkinson	( ) Other:
( ) Glaucoma	( ) Pinched Nerve	

Exercise:	**Work Habits:**	**Other Habits:**
( ) none	( ) sitting	( ) smoking Packs/Day_____
( ) mild	( ) standing	( ) drinking Drinks/Week_____
( ) moderate	( ) light labor	( ) coffee/caffeine Cups/Day_____
( ) heavy	( ) heavy labor	( ) stress Reason_____

Pregnancy history: # of pregnancies_____ # of live births_____

# of miscarriages_____ vaginal/C-section?_____ are you pregnant now?_____

If yes, due date?_____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
Please list medications, what they are for, and how long you have been taking them:		Please list supplements you are currently taking, where you purchased them, and the dose (if known):
1._____	_____	1._____
2._____	_____	2._____
3._____	_____	3._____
4. _____	_____	4. _____