

**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: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_ OK to call at work?  Yes  No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Marital Status: S M D W Sex: M F Name of Spouse: \_\_\_\_\_

Ages & Names of Children: \_\_\_\_\_

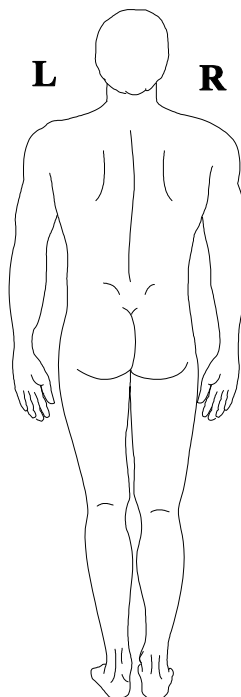
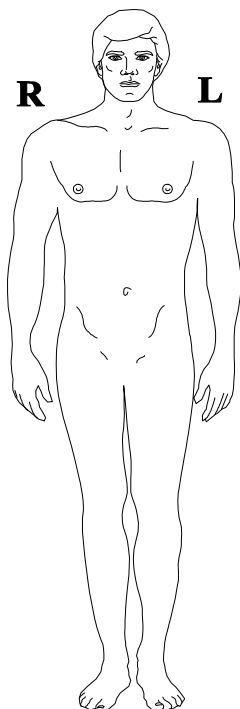
Who Referred You To Our Office Or How Did You Hear About Us? \_\_\_\_\_

Have You Had Previous Chiropractic Care?  No  Yes; if so please indicate when and the doctors name: \_\_\_\_\_

Date of Your Last Physical Examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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***

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Blurring vision  | <input type="checkbox"/> Buzzing or ringing in ears | <input type="checkbox"/> Headaches: Area of head: _____                                    |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Numbness                   | How often: <input type="checkbox"/> daily <input type="checkbox"/> ____ times per day      |
| <input type="checkbox"/> Loss of bowel or bladder function                        | <input type="checkbox"/> Confusion                  | <input type="checkbox"/> ____ times per week <input type="checkbox"/> ____ times per month |
| <input type="checkbox"/> Constipation   | <input type="checkbox"/> Loss of sleep              | <input type="checkbox"/> Chest pains   |
| <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Stomach difficulty         | <input type="checkbox"/> Painful urination   |
| <input type="checkbox"/> Rectal bleeding  | <input type="checkbox"/> Frequent urination         | <input type="checkbox"/> Difficulty swallowing   |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Frequent colds             | <input type="checkbox"/> Hay fever   |
| Do you have a pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

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

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

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### **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 menstrual cycle: \_\_\_\_\_

## ***SURGICAL HISTORY***

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

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## ***FAMILY HISTORY***

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

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## ***SOCIAL HISTORY***

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Do you smoke?  No  Yes If yes, how many packs 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:

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

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## ***WORK HISTORY***

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How many hours do you normally work in a week? \_\_\_\_\_ Are you currently not working?  Yes  No

In a typical workday, I: (circle the number of hours per day per activity)

Sit	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk	1	2	3	4	5	6	7	8	hours

On the job, I perform the following activities:

In terms of an 8-hour workday, "occasionally" = 33%, "frequently" = 34% to 66%, and "continuously" = 67% to 100% of the day.

	Not At All	Occasionally	Frequently	Continuously
Bend / Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing / Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check the category that best describes your work:

- Sedentary:** Lifting up to 10 lbs. maximum and occasionally lifting and / or carrying such articles as docket, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking is required only occasionally and other sedentary criteria are met.
- Light Work:** Lifting 20 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 10 lbs. Even though the weight lifting may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling or arm and / or leg controls.
- Medium Work:** Lifting 50 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 25 lbs.
- Heavy Work:** Lifting 100 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 50 lbs.
- Very Heavy Work:** Lifting objects in excess of 100 lbs. with frequent lifting and / or carrying of objects weighing 50 lbs. or more.

## ***CERTIFICATION AND ASSIGNMENT***

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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:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

(or guardian if child)

## Odenton Chiropractic 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 Odenton 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| Have a patient sign-in sheet that will be seen by other patients  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have a personal discussion with me in common areas of the office  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Call me regarding appointments at the telephone number(s) listed in my records  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Leave a message on an answering machine or with a family member regarding appointments, at the telephone number(s) listed in my records | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Leave a message at my place(s) of employment, regarding appointments, at the telephone number(s) listed in my records                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Call to request test results on my behalf from imaging centers, labs, or other referred specialists                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

## **Odenton Chiropractic Financial Policy**

Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. If you have any questions or concerns about our payment policy please call the office.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, check and credit card for your convenience. We will be happy to process your insurance claim for you; please bring forms if appropriate.

In special instance, we accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and your insurance company. OUR relationship is with you, not your insurance company.
2. All charges are your responsibility whether or not your insurance company pays. Not all services are a covered benefit in all insurance contracts. A telephone inquiry on your behalf is a courtesy call and as stated by the representative, this benefit quote is not a guarantee of benefits.
3. In cases where your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring us the referral. If there is no referral present at the time of your chiropractic visit, it is your responsibility to cover the professional fees for the visit.
4. Fees for these services along with unpaid deductibles and co-payments are due at the time of treatment.
5. We accept personal checks. However, a \$25.00 fee applies for all returned checks.
6. In cases where financial payment are arranged, a late charge of \$5.00/ month will be assessed on all over due balances beginning on the 60<sup>th</sup> day.

Please note that unless canceled at least 24 hours in advance, there is a charge for missed appointments at the normal office visit rate (not covered by insurance). Please call if you have to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_