

PATIENT HEALTH QUESTIONNAIRE - PHQ



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?

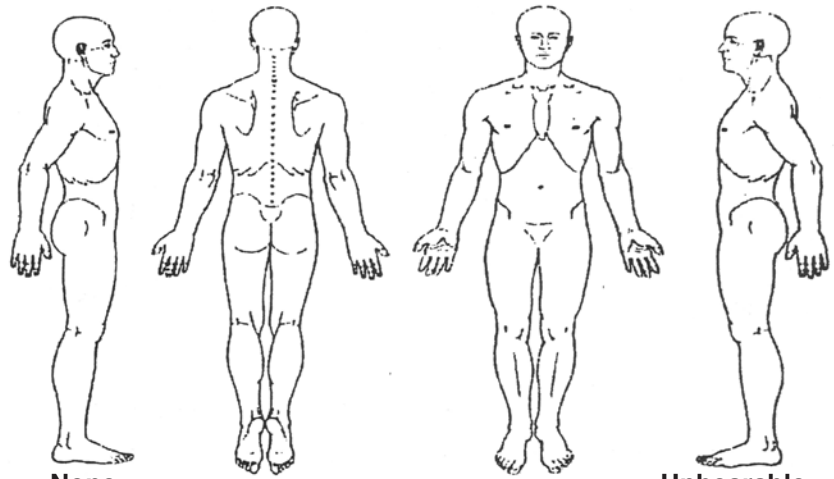
- 1. Sharp
- 2. Dull ache
- 3. Numb
- 4. Shooting
- 5. Burning
- 6. Tingling

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 0 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

a. What treatments did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

1. X-rays date: _____ 3. CT Scan date: _____
 2. MRI 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
- 7. Off Work
- 8. Other

Patient Signature _____

Date _____

PATIENT HISTORY



Please check the following conditions you presently have or have had:

- | | | | |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stress (home) |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stress (work) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headache | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whiplash |
- Allergies: _____
 Other: _____

DRUGS / MEDICATIONS YOU HAVE TAKEN OR ARE PRESENTLY TAKING:

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Pain killers | <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Tranquillizers | <input type="checkbox"/> Insulin | <input type="checkbox"/> Diuretics | <input type="checkbox"/> Corticosteroids |
- Allergies to Medications: _____
 Other: _____

SURGERY HISTORY:

- | | | | |
|---------------------------------------|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Tonsils | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Spinal/Back |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Prostate | <input type="checkbox"/> Cyst | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Ankle | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Wrist |
- Other: _____

Have you ever been hospitalized for any reason other than surgery? Yes No

If yes, please explain: _____

Have you had Nursing Home or Rehabilitation Care? Yes No

If yes, please explain: _____

Have you had any concussions, dislocation, or fractures (broken bones): Yes No

If yes, please explain: _____

Family History:

Relation	Diabetes	Heart	Kidney	Cancer	Back
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother, No. of _____	_____	_____	_____	_____	_____
Sister, No. of _____	_____	_____	_____	_____	_____

Accident? Yes No If yes, Accident date _____ Onset date _____

Do you smoke? Yes No If yes, How much? _____ How Long? _____

After reading and filling out this history, your signature validates all of the information you have given us is accurate and reflects your current health status. Please sign below:

Patient Signature: _____

FOR DOCTORS USE ONLY

Doctor's Notes: _____	BP: _____
_____	O2: _____
_____	PULSE: _____
_____	TEMP: _____
_____	HEIGHT: _____ "
_____	WEIGHT _____ LBS.
_____	BMI: _____
_____	CHILD 2-20 GROWTH _____

CASE HISTORY

(Please Print)



Address _____ Phone _____

City _____ State _____ Zip _____

Married _____ Single _____ Number of Children _____

AGE _____ PREFERRED LANGUAGE _____ DATE OF BIRTH _____ GENDER _____

Race: Caucasian African American Hispanic Asian Other _____ Ethnicity(origin ex. German) _____

Employed by _____ Business Phone _____

Referred by _____

Have you had chiropractic care before? _____ Where? _____

Social Security No. _____ Who is responsible for account? (if minor) _____

(NAME) (ADDRESS)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chiro-Works will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Chiro-Works 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 payment. (I further understand that any unpaid balance of 60 days or more will be charged 1.5% interest on the unpaid balance each month.) In the event that I fail to pay the amounts when due, I understand that I will be in default of our agreement.
DELINQUENCY AND DEFAULT: I AGREE TO PAY THE COSTS INCURRED TO COLLECT THIS BILL IN THE EVENT OF MY DEFAULT IN PAYMENT, INCLUDING YOUR REASONABLE ATTORNEY'S FEES.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS AND/OR INFORMATION

I authorize Chiro-Works to release any medical information or X-rays as needed to process claims for services rendered. I understand that this release is revocable at any time prior to the release of this information.

ASSIGNMENT OF PAYMENT

My attorney and/or insurance company are hereby requested and authorized to pay direct to Chiro-Works any monies due on account, the same to be deducted from any settlement made on our behalf.

Further, I agree to pay Chiro-Works the difference, if any between the total amount of charges and the amount paid by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay Chiro-Works the full amount of charges, should my condition be such that it is not covered by my policy or it for any reason the insurance company refuses to pay my claim.

Dated at 1019 W. Galena Ave., Freeport, IL 61032 this _____ day of _____, 20_____.

Witness:

Signature of Patient or Legal Guardian