

**HEINZE FAMILY CHIROPRACTIC**  
**PERSONAL INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First Middle Initial

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 Due Date \_\_\_\_\_

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:

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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 Doctor's Name \_\_\_\_\_

Do you exercise regularly?  Yes  No

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

Newspaper  Yellow Pages  Radio  TV  Other  Patient (Patients Name: \_\_\_\_\_)

Email: \_\_\_\_\_

# Patient Health Questionnaire-PHQ

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

\_\_\_\_\_

a. When did your symptoms start?

b. How did your symptoms start?

\_\_\_\_\_

\_\_\_\_\_

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

## 3. What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling

## 4. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

## 5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms (1 meaning none, 10 meaning unbearable)

|   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|----|
| 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?

(like visiting with friends, relatives, ect)

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

## 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?

|                                |             |                                  |             |
|--------------------------------|-------------|----------------------------------|-------------|
| <input type="checkbox"/> Xrays | date: _____ | <input type="checkbox"/> CT Scan | date: _____ |
| <input type="checkbox"/> MRI   | date: _____ | <input type="checkbox"/> Other   | date: _____ |

## 9. Have you had similar symptoms in the past?

- Yes
- No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- This Office
- Medical Doctor
- Other
- Other Chiropractor
- Physical Therapist

## 10. What is your occupation?

\_\_\_\_\_

- Professional/Executive
- White Collar/Secretarial
- Tradesperson
- Laborer
- Homemaker
- FT Student
- Retired
- Other

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

Date \_\_\_\_\_

**Patient Health Questionnaire – page 2**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What type of regular exercise do you perform?  None  Light  Moderate  Strenuous

What is your height and weight? Height    Weight    lbs.

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 have presently have a condition listed below, place a check in the Present column.

|                          |                          |                          |                          |                          |                             |                          |                          |                                     |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|-------------------------------------|
| <b>Past</b>              | <b>Present</b>           |                          | <b>Past</b>              | <b>Present</b>           |                             | <b>Past</b>              | <b>Present</b>           |                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches                | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain                | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain          | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains                 | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                      |                          |                          |                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Angina                      | <input type="checkbox"/> | <input type="checkbox"/> | Smoking/Use Tobacco Products        |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain            | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones               | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependence             |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm Pain                 | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders            |                          |                          |                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow Pain               | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection           | <input type="checkbox"/> | <input type="checkbox"/> | Allergies                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain               | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination           | <input type="checkbox"/> | <input type="checkbox"/> | Depression                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain                | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control     | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip Pain                 | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems           | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg Pain                 |                          |                          |                             | <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash              |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee Pain                | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain/Loss   |                          | <input type="checkbox"/> | HIV/AIDS                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle Pain               | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite            |                          |                          |                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot Pain                | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain              |                          |                          |                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain                 | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer                       |                          |                          | <b>Females Only</b>                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Swelling/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                   | <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                | <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Hormonal Replacement                |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis     | <input type="checkbox"/> | <input type="checkbox"/> | Cancer                      | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy                           |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue          | <input type="checkbox"/> | <input type="checkbox"/> | Tumor                       |                          |                          |                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination  | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                      | <input type="checkbox"/> | <input type="checkbox"/> | <b>Other Health Problems/Issues</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances      | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis           | <input type="checkbox"/> | <input type="checkbox"/> |                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                |                          |                          |                             | <input type="checkbox"/> | <input type="checkbox"/> |                                     |

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 \_\_\_\_\_