

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?

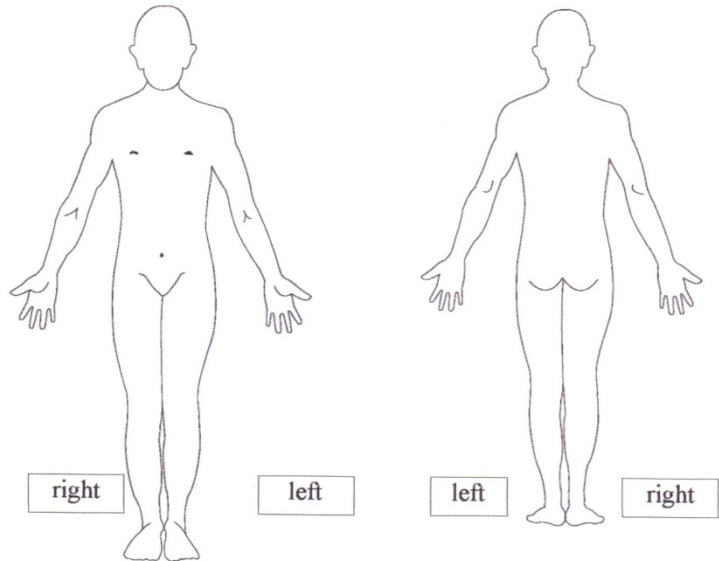
Indicate where you have pain or other symptom.

- 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?

Please indicate type of pain on the pictures →

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



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

None	0	1	2	3	4	5	6	7	8	9	10	Unbearable
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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
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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
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7. In general would you say your overall health right now is...

Excellent	Very Good	Good	Fair	Poor
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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.

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

Exercise: <input type="checkbox"/> () none <input type="checkbox"/> () mild <input type="checkbox"/> () moderate <input type="checkbox"/> () heavy	Work Habits: <input type="checkbox"/> () sitting <input type="checkbox"/> () standing <input type="checkbox"/> () light labor <input type="checkbox"/> () heavy labor	Other Habits: <input type="checkbox"/> () smoking Packs/Day _____ <input type="checkbox"/> () drinking Drinks/Week _____ <input type="checkbox"/> () coffee/caffeine Cups/Day _____ <input type="checkbox"/> () stress Reason _____
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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: 1. _____ 2. _____ 3. _____ 4. _____	_____ _____ _____ _____	Please list supplements you are currently taking, where you purchased them, and the dose (if known): 1. _____ 2. _____ 3. _____ 4. _____