Athens Chiropractic Clinic **Patient Present Complaints**

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Cell # _____ Social Security# _____ Driver Lic.# _____

Age _____ Birthdate ____/____/____ Sex M / F ____ Status M S W D _____ No. Children _____

Occupation _____ Employer _____ Years Employed _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Ext. _____ Referred By: _____

Spouse's Name _____ Occupation _____ Employer _____ Soc. Sec.# _____

Person Responsible for this Account _____ HealthPlan _____

Subscriber's Name _____ ID# _____ Group# _____

Please describe your problem and how it began. ***Date problem began:*** ___/___/___

_____

_____

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

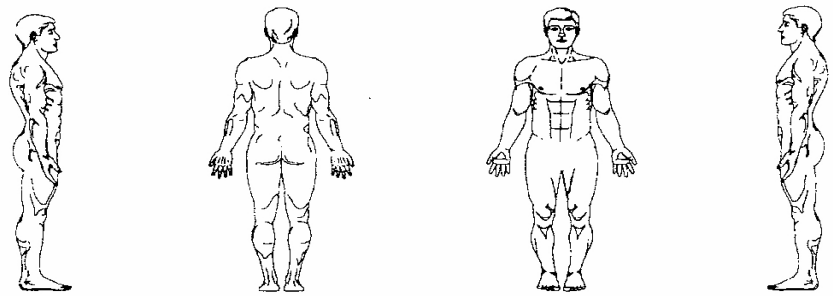
Describe your current pain/symptoms:	☐ Sharp/Stabbing	☐ Throbbing	☐ Aches
	☐ Dull	☐ Soreness	☐ Weakness
	☐ Numbness	☐ Shooting	☐ Gripping
	☐ Burning	☐ Tingling	☐ Other _____
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change
What makes the problem better?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ Inactivity/rest	☐ Other _____
What makes the problem worse?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ inactivity/rest	☐ Other _____
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting	☐ Light Labor	☐ Heavy Labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

_____

Have you had X-rays, MRI or other tests for this condition? What tests and When? _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: _____ Date: _____

Athens Chiropractic Clinic **Patient Health Questionnaire**

Patient Name_____Patient ID#_____

If you have *ever* had a listed symptom in the *past,* please check that symptom in the *Past Column.* If you are *presently* troubled by a particular symptom, check that symptom in the *Present column.* **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R_____ L_____)
☐	☐	Pain in Upper Arm or Elbow (R_____ L_____)
☐	☐	Hand Pain (R_____ L_____
☐	☐	Wrist Pain (R_____ L_____
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R_____ L_____)
☐	☐	Pain in Lower Leg or Knee (R_____ L_____)
☐	☐	Pain in Ankle or Foot (R_____ L_____)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight
	☐ Gain	☐ Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstral Flow
☐	☐	Profuse Menstral Flow
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date)_____
☐	☐	Stroke (date)_____
☐	☐	Asthma
☐	☐	Cancer, Explain_____
☐	☐	Tumor, Explain_____
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver / Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other_____

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other _____
☐ High Blood Pressure_____	

Do you have a permanent disability rating? **Yes** **No**

Location_____

Date rating received_____

Rating Percentage_____

Present Weight_____pounds

Height _____feet _____inches

Please check any of the following that apply to you.

Past	Present	Condition
☐	☐	Pregnancy, # births_____
☐	☐	Birth Control Pills, type_____
☐	☐	Medications (list if not listed elsewhere)
		_____
☐	☐	Hospitalizations/Surgical Procedures

Past	Present	Condition
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffinated Soft drinks: cups/cans per day:_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature:_____ Date: _____