

PATIENT HEALTH QUESTIONNAIRE

Name _____ Date _____

Please fill in the blanks and check all items where appropriate. In the space below, please describe the present complaint(s) which brought you to our office. When finished, please complete the reverse side. This information will assist us in obtaining an early understanding of your health.

Present complaint _____

When did this problem begin? _____

How did this problem begin? After a specific incident Multiple incidents Slowly over time
 Please explain _____

What treatment have you received for this present complaint? Chiropractor MD Therapist none
 other _____ Specify dates of treatment and results _____

Describe the character of your current pain Burning Diffuse Dull Ache Localized Radiation
 Sharp Shooting Stabbing Throbbing Tightness Tingle Other: _____

How often is the complaint present? With Activity Intermittent Constant
 Morning Afternoon Night

Please rate your pain:

At Rest: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)
 Active: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

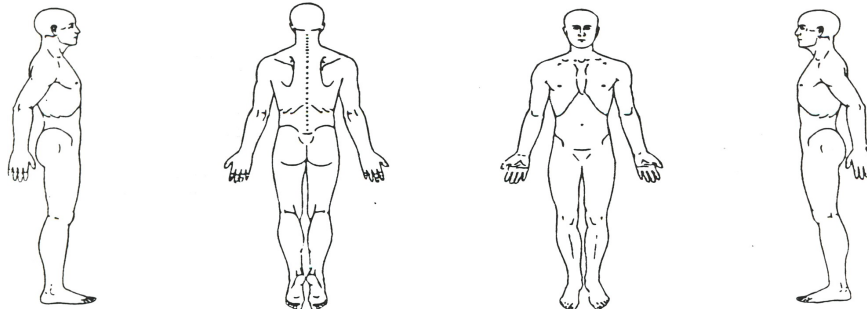
Since your problem started is the pain increasing unchanged decreasing

What can you do to make the pain better? _____

What do you do that makes the pain worse? _____

Worse with: Cold Temps Warm Temps Dampness

Please outline on the diagram the area of your discomfort. A=Aches, B=Burning, P= Pins & Needles, S=Stabbing, O=Other



Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Review Of Systems- Please fill out all of the sections, even if “DENY”.

Musculoskeletal - Deny any musculoskeletal Issue (s)

- Neck Pain Shoulder Pain Hand Pain
- Arm or Elbow Pain Upper Back Pain Knee Pain
- Lower Back Pain Foot or Ankle Pain Leg Pain
- Swelling of joints Stiffness of joints Jaw Pain
- Headaches

Constitutional- Deny any constitutional Issue (s)

- Chills Fatigue
- Weight Gain Fever
- Daytime Somnolence (Drowsiness)
- Night Sweats Wt. Loss

Eyes/Vision- Deny any eyes/vision issue(s)

- Blindness Blurred Vision
- Eye Pain Field Cuts
- Tearing Glasses/ contacts
- Cataracts Glaucoma
- Change in vision Itching (eyes)
- Double Vision Photophobia

Ears, Nose & Throat- Deny any ears, nose, throat issue(s)

- Bleeding Dizziness Sinus Infections
- Headaches Nasal Congestion
- TMJ Snoring Dental implants
- Fainting Ear Drainage Head Injury
- Loss of smell Nose Bleeds
- Sore Throats Dentures Ear Infections
- Discharge Hearing loss Post Nasal Drip
- Rhinorrhea (runny nose) Tinnitus (ringing in ears)
- Difficulty Swallowing Ear Pain
- Hoarseness

Respiration- Deny any respiration issue(s)

- Asthma Cough
- Coughing up Blood Shortness of Breath
- Sputum Production Wheezing

Cardiovascular- Deny any cardio system issue(s)

- Angina (chest pain) Heart Problems
- Claudication (leg pain) Heart murmur
- Swelling of legs High Blood Pressure
- Orthopnea (difficulty breathing while lying down)
- Palpitations (irregular or forceful beating of heart)
- Shortness of breath with exertion or exercise
- Ulcers Varicose Veins

Gastrointestinal- Deny any gastrointestinal issue(s)

- Abdominal Pain Difficulty swallowing
- Nausea Abnormal stool
- Belching Heartburn
- Rectal Bleeding Black, tarry stool
- Hemorrhoids Vomiting
- Constipation Indigestion
- Vomiting Blood Diarrhea
- Jaundice (yellow skin) Abnormal Stool

Female- Deny any female issue(s)

- Birth control therapy Breast lumps/ pain
- Burning urination Cramps
- Frequent Urination Hormone therapy
- Irregular Menstruation Urine Retention
- Vaginal Bleeding Vaginal discharge
- Are you pregnant? Yes / No
- Date of last period: _____

Male- Deny any male issue(s)

- Burning urination Erectile dysfunction
- Prostate problems Urine retention
- Frequent urination Hesitancy/ dribbling

Endocrine- Deny any endocrine issue(s)

- Cold intolerance Frequent urination
- Voice changes Diabetes
- Goiter Excessive appetite
- Hair loss Excessive hunger
- Heat intolerance Excessive thirst
- Unusual hair growth

Skin- Deny any skin issue(s)

- Changes in nail texture Changes in skin color
- Hair growth Hair loss
- Hives Itching
- Paresthesia (numbness, prickling, tingling)
- Rash
- History of skin disorders Skin lesions/ ulcers
- Varicosities

Nervous System- Deny any nervous system issue(s)

- Dizziness Memory loss Stress
- Facial weakness Numbness Strokes
- Headaches Seizures Tremors
- Limb weakness Sleep disturbances
- Unsteadiness of gait Loss of consciousness
- Slurred speech

Psychological- Deny any psychological issue(s)

- Anhedonia Bipolar disorder
- Mood changes Confusion
- Convulsions Anxiety
- Depression Appetite changes
- Insomnia Behavioral changes
- Memory loss

Allergy- Deny any allergy system issue(s)

- Anaphylaxis (history of) Food intolerance
- Itching Nasal Congestion
- Sneezing

Hematology- Deny any hematology issue(s)

- Anemia Bleeding
- Blood clotting Blood transfusion
- Bruises easy Fatigue
- Lymph node swelling

CONFIDENTIAL PATIENT INFORMATION SHEET

Name _____ Date _____

Spouse's Name _____ Children's Names _____

Address _____

City _____ State _____ Zip Code _____

Phone #'s: Cell _____ Work _____ Home _____

E-mail address: _____

Drivers License # _____ Social Security # _____

Birth date _____ Marital Status: M S W D

Occupation _____ Employer _____

In case of emergency contact person and phone # _____

How did you hear about our office? _____

Do you have health insurance? Yes No

Name of Policy Holder _____ Social Security # _____

Birth date _____ Policy Holder's Employer _____

Insurance Company _____

Policy Number _____ Group Number _____

Past Health History:

Major Surgeries/ Operations: _____

Broken Bones: _____ Major Accidents/Falls: _____

Hospitalizations: _____

Previous Chiropractic Care: _____ Dr. Name & date of last visit: _____

Current Medications: _____

Intake: Caffeinated beverages Alcohol White Sugar
 Tobacco products Illegal drugs

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

RELIEF CARE CORRECTIVE CARE

WOULD LIKE THE DOCTOR TO SELECT THE TYPE OF CARE APPROPRIATE FOR YOUR CONDITION.

DATE

PATIENT'S SIGNATURE

RELIEF CARE

Relief care is that care necessary to get rid of your symptoms or pain, but not that cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between the 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 fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to evaluate and/or treat my condition, as he deems appropriate. It is understood and agreed that the amount paid to the Doctor, for x-rays, is for examination only. And the 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 bills incurred at this office.

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's
Signature of Authorizing Care _____ Date _____

(If Minor) Name of Guarantor _____ Birthdate _____

Social Security # _____ Address _____

Please list your current physicians. We believe a teamwork approach to your healthcare will give you the best results and would like to keep your physicians informed regarding your care.

I authorize Peak Performance Chiropractic to send my medical information to the following physicians:

| <u>Dr. Name:</u> | <u>Clinic:</u> | <u>Address:</u> | <u>Phone:</u> |
|------------------|----------------|-----------------|---------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Patient Signature: _____ Date: _____

Print Name: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **Peak Performance Chiropractic's** Notice of Privacy Practices has been provided to me. I understand I have a right to review it prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Peak Performance Chiropractic**. The Notice of Privacy Practices for **Peak Performance Chiropractic** is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and **Peak Performance Chiropractic's** duties with respect to my protected health information.

Peak Performance Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Please check any activities you participate in, and how they are impacted by your condition:

| | No Effect | Mild – Painful | Moderate – Painful | Severe –Unable to do |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| DAILY | | | | |
| Bending | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Care for family member | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Carrying groceries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Change position: sit-stand | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Driving | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Extended computer use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Household chores | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kneeling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lift children | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pet care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reading (concentration) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-care (bathing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-care (dressing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-care (shaving) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Static sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Static standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Yard Work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please check any activities you participate in, and how they are impacted by your condition:

| | No Effect | Mild – Painful | Moderate – Painful | Severe –Unable to do |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| RECREATION | | | | |
| Baseball | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Basketball | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bingo | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Boating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bungee Jumping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Camping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ceramics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cheer-leading | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Church | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coaching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cooking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crafts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cycling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dancing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fishing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Football | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gardening | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Golf | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gymnastics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hiking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hockey | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Horseback Riding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hunting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lacrosse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Martial Arts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Motorcycling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pilates | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Playing Musical Instrument | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Playing Pool | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rock Climbing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rollerblading | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Running | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sewing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Snow Skiing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Soccer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Softball | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skydiving | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Swimming | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tennis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Volleyball | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking for Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Water Skiing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| White Water Rafting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Woodworking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wrestling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Yard Work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Yoga | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Video Documentation

Our office is concerned with providing the highest level of service. We may video/audio record some or all of our patient interactions for quality control, documentation, and training purposes. All information is considered protected health information, and covered under our HIPPA privacy policies.

I understand and consent to Peak Performance Chiropractic's video quality assurance and documentation.

Print name _____

Signature _____

Date _____