FOR OFFICE USE ONLY

PERSONAL HISTORY

Date: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Birthdate: _____ Age: _____ Sex: ☐ M ☐ F

Social Security Number: _____ **Cell Phone:** _____

Business/Employer: _____ Type of Work: _____

Business Phone: _____ Circle One: Married Single Widowed Divorced Separated No. of Children _____

Name of Spouse: _____ Spouse's Birthdate: _____

Spouse's Business Phone: _____ Spouse's Employer: _____

Type of Work: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Referred To This Office By: _____

Who Is Responsible For Your Bill: ☐ Self ☐ Personal Health Insurance ☐ Medicare ☐ Workman's Comp. ☐ Auto Insurance

Name of Insured: _____

Insurance Company Name: _____ Policy/Claim Number: _____

Address: _____ Contact Person: _____

Phone No.: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Kelman'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 this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____

(If patient is a minor, signature of parent, guardian, etc.)

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Related ☐ Home Injury ☐ Fall ☐ Other _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report Of Your Accident To Your Employer?: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accidents Or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date Of Last Visit: _____

Patient Health Questionnaire - PHQ

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

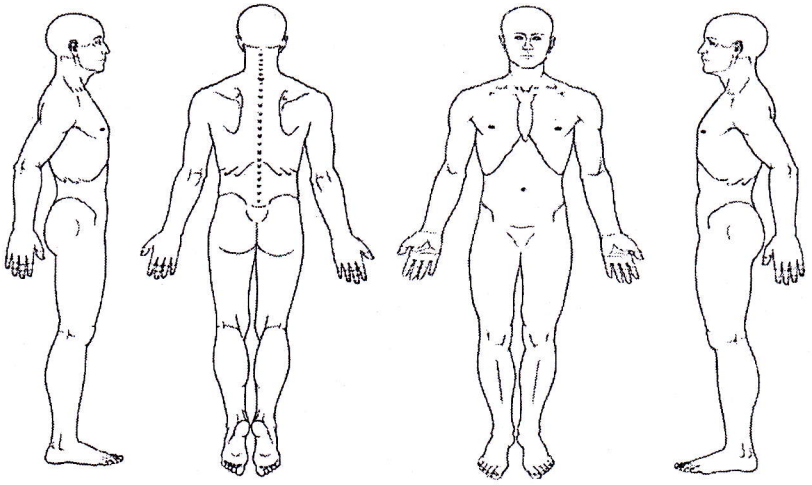
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your 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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

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

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

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 <u>past 4 weeks</u> 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

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8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

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

① Xrays *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 ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ ***Date*** _____