PATIENT HEALTH QUESTIONNAIRE

Name____ Date ______________________________

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, check that symptom in the Present column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight Gain / Loss
☐	☐	Angina
☐	☐	Anorexia
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast Soreness Lumps
☐	☐	Cancer, Explain_______________
☐	☐	Chest Pains
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Colitis
☐	☐	Constipation/irregular bowel habits
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty in Swallowing
☐	☐	Dizziness
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Excessive Thirst
☐	☐	Fainting
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Headaches - Frequency? _____________
☐	☐	Heart Attack (date)
☐	☐	Heartburn/Indigestion
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Irregular Menstrual Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain (TMJ Pain)
☐	☐	Kidney Disorders (by condition)
☐	☐	Kidney Stones
☐	☐	Liver/Gallbladder problems
☐	☐	Loss of Appetite

Past	Present	Condition
☐	☐	Loss of Bladder Control
☐	☐	Low Back Pain
☐	☐	Mid Back Pain
☐	☐	Muscular In-coordination
☐	☐	Neck Pain
☐	☐	Pain in Ankle or Foot
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Upper Arm or Elbow
☐	☐	Pain in Upper Leg or Hip
☐	☐	Painful Urination
☐	☐	PMS
☐	☐	Profuse Menstrual Flow
☐	☐	Prostate Problems
☐	☐	Rapid Heart Beat
☐	☐	Rheumatoid Arthritis
☐	☐	Scoliosis
☐	☐	Shoulder Pain
☐	☐	Stroke (Date)_____________
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Tinnitus (Ear Noises)
☐	☐	Tumor, Explain___________
☐	☐	Ulcer
☐	☐	Visual Disturbances
☐	☐	Wrist Pain
☐	☐	Other___________________

Have You or Your Family Had:

Yes	**No**	
☐	☐	Cancer
☐	☐	Rheumatoid Arthritis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Chronic Back Problems
☐	☐	Heart Problems
☐	☐	Chronic Headaches
☐	☐	Lung Problems
☐	☐	High Blood Pressure
☐	☐	Lupus

Do you have a permanent disability rating? Yes__ No__

Location_______________________________________

Date rating received? Rating Percentage__________

Height _________**Feet** _______**Inches** **Weight** _______**Pounds**

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy, # births____________
☐	☐	Birth control pills, Type________
☐	☐	Medication (list if not listed elsewhere) _______________________________ _______________________________

Past	Present	
☐	☐	Tobacco___ packs/day
☐	☐	Alcohol __drinks/day/week/month
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft drinks
☐	☐	______cups/cans per day

Past	Present	
☐	☐	Hospitalizations/Surgical Procedures (List if not described elsewhere)_______________________

____

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

____ ______________________

Signature **Date**

APPLICATION FOR TREATMENT

Date ______________________

Name____Age_____Birthdate__________
Address ____City _________________ State _____ ZIP_________
Home Phone _______________________ Phone at Work __________________ Cell Phone ___________________
E-Mail Address____________________________ Primary Care Physician__________________________________
May we contact you via e-mail for monthly newsletters and/or announcements? **Yes** **No**
Whom should we thank for the Referral? ____
Circle if you are: Married Single Widowed Divorced Separated
Employer ____Occupation __________________________________

●Please describe the main reason(s) for which you came to this office. ___________________________________
____

●On a scale from 0-10, with 10 being unbearable pain, how severe is your pain? **0 1 2 3 4 5 6 7 8 9 10**

●**When and how did symptoms first occur?** ____
____
____

●List any other doctors seen for these problems ____
____

●List diagnosis(es) and type of treatment(s) ____
____

●**Does this interfere with your normal living and work? Yes No If yes, In what way?** ___________________
____
____

●Have you lost any days of work? **Yes No Dates** ____

●Have you had similar symptoms or injuries before? **Yes No If yes, explain** ___________________________
____

●List the names of any relatives that have or have had a similar problem _______________________________
____

●Who is responsible for your bill (pleases circle)? Self Spouse Employer Insurance Other____________

PAST HISTORY

●Has a physician treated you for any health condition in the last year? **Yes No If yes, explain:** _______________
____

●Have you or any relative received Chiropractic treatment previously? **Yes No If yes, explain:** ______________
____

●List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones) ____
●List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.)__________
____

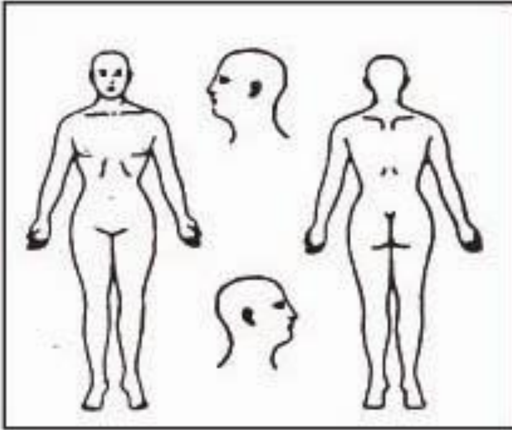
FAMILY CONTACTS

Name of wife or husband _____________________________________ Ages of children ______________________
Spouse's Employer ____ Business Phone _______________
Your Nearest Relative ____
Relative's Address____ Phone Number _________________

PLEASE TURN OVER

CURRENT CONDITION

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

CONSENT TO RECEIVE TREATMENT

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient ______________________ **Date** ______________________

INSURANCE INFO

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Paporto Chiropractic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signature______________________________Date______________

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.(PLEASE CIRCLE)

1. Do you or your spouse work for a company that provides you with health insurance? **Yes** **No**
2. Are you entitled to Medicare because of End Stage Renal Disease? **Yes** **No**
3. Is this illness or injury the result of an accident or other injury? **Yes** **No**
4. Is this illness or injury the result of an accident or illness that occurred at work? **Yes** **No**
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? **Yes** **No**
6. Are you entitled to any benefits under the Federal Black Lung Program? **Yes** **No**
7. Do you have a Medicare Medigap Policy? **Yes** **No**
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from) **Yes** **No**

Signature ______________________________Date ____________