

Tannenbaum Chiropractic

4059 Stone School Road, Ann Arbor, MI 48108
 (734) 929-0444

PATIENT HEALTH QUESTIONNAIRE

Last Name _____

First Name _____ Middle Initial _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Alternate # (____) _____ - _____

Work Phone (____) _____ - _____ ext # _____ Email _____

Soc. Sec # _____ Birthday ____/____/____

Age ____ Sex M / F Status M LTR S W D # of children and ages _____

Occupation _____ Employer _____ Years Employed _____

Address _____

City _____ State _____ Zip _____

Spouse or Partner's Name _____ Soc. Sec. # _____

Occupation _____ Employer _____

Person Responsible for this Account _____ Health Plan _____

Subscriber's Name _____ ID# _____ Group# _____

1. **How did you hear about our office?** _____

2. **Is your injury related to work?** NO YES

If Yes, date of injury ____/____/____

Did you the report injury to your supervisor? NO YES

3. **Is your injury related to an auto accident?** NO YES

If Yes, date of accident ____/____/____

Was a police report filed? NO YES

4. **How do you intend to pay for today's visit?** _____

5. **Please list the name of your primary physician (who cares for you & your family)**

Doctor's Name: _____

Doctor's Address: _____

I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that this office will prepare initial billings to assist me in making collections from the insurance company and that any amount authorized will be credited to my account on receipt. I clearly understand and agree that I am responsible for payment of all services rendered to me.

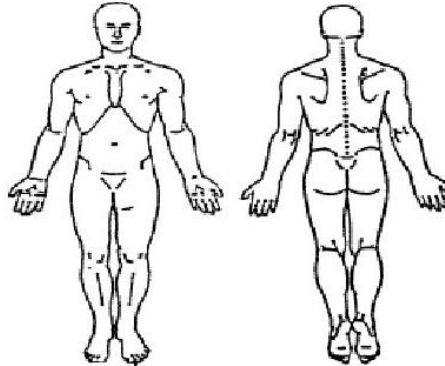
Patient/Guardian Signature _____ Today's date _____

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PATIENT HEALTH QUESTIONNAIRE

NAME _____ DATE _____



PLEASE MARK THE AREAS OF YOUR COMPLAINT OR SYMPTOMS

What is the primary reason for your visit today? _____

1. Please describe your complaint: Sharp Pain Dull Pain Ache Weak Throbbing Numbness & Tingling Shooting Burning
2. Frequency: Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)
3. Indicate intensity of your pain at its lowest and highest level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Are your symptoms Improving Not changing Getting worse

Symptoms are worse in the Morning Afternoon Night Same all day.

4. Does the problem/pain radiate or travel (shoot) to any other areas in your body? Where? _____
5. Do you have any numbness or tingling in your body? Where? _____
6. When did your problem begin? (GIVE SPECIFIC DATE IF POSSIBLE) _____
7. Describe how your problem began: _____
8. Have you been treated for this condition before Yes No
9. If yes, by whom? Chiropractor Medical Doctor Physical Therapist Massage Therapist Other _____ Are you currently being seen? Yes No If so, how often and what treatments? _____
10. What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity
11. What makes your problem worse? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity
12. How would you rate your general stress level? Little or no stress Minimal stress Moderate stress Greatly stressed
13. General Physical Activity: No regular exercise Light exercise Moderate exercise Strenuous exercise
14. Are your complaints affecting your ability to be active? Check appropriate box. No effect Able to do light duty work & household tasks.
 Need limited assistance to perform tasks. Need assistance often, have a significant inability to function without assistance.
I am totally disabled (impaired), cannot care for myself.
15. Physical activity at work: Sitting 50% or more of work day Light manual labor Manual labor Heavy manual labor Repetitive motion
16. Has your work status changed because of this complaint? YES NO
17. What is your current work status? Full time, no restrictions Full time, with restrictions Part time, no restrictions Part time, with restrictions. Off work due to restrictions Unemployed. Retired, restrictions Full time homemaker Full time student
18. Do you have a permanent disability? Location _____ Rating Percentage _____ % Date received _____

Tannenbaum Chiropractic4059 Stone School Road
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Mark All That Apply:

Symptom	Past	Present	Symptom	Past	Present	Symptom	Past	Present
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Wrist/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Stiff/Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

PRESENT HEALTH STATUS

Height: _____ Ft. _____ In. Weight _____ lbs.

Tobacco Use: Never Infrequent 1/2 pack/wk Moderate 1 pack/wk Heavy 2+ Packs/wkAlcohol Use: Never Infrequent 1-2 per wk Moderate 3-5 per wk Heavy 6+ per wkCaffeine Use: Never Infrequent 1-2 per wk Moderate 3-5 per wk Heavy 6+ per wkDrug/Medications:
_____Surgeries/Hospitalizations:
_____Previous Illnesses:
_____Previous Traumas:
_____**PRESENT HEALTH STATUS**

Please check the appropriate boxes if there is a history of family illness:

Circle M for mother's side of family, F for father's side of family.

<input type="checkbox"/> Heart Disease	M	F	<input type="checkbox"/> Back Problems	M	F
<input type="checkbox"/> High Blood Pressure	M	F	<input type="checkbox"/> Migraines	M	F
<input type="checkbox"/> Lung Problems	M	F	<input type="checkbox"/> Epilepsy/Seizures	M	F
<input type="checkbox"/> Arthritis	M	F	<input type="checkbox"/> Allergies/Asthma	M	F
<input type="checkbox"/> Diabetes	M	F	<input type="checkbox"/> Cancer	M	F

Patient/Guardian Signature _____ Date _____