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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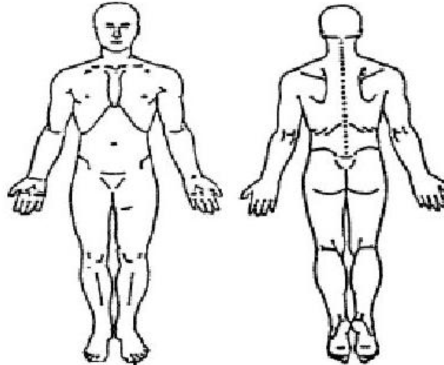
NAME____ **DATE** ____________________



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 _______

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HEALTH HISTORY

Mark All That Apply:

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

PRESENT HEALTH STATUS

Height: ______Ft. _____In. Weight _____lbs.

Tobacco Use: θ Never θInfrequent 1/2 pack/wk θ Moderate 1 pack/wk θHeavy 2+ Packs/wk

Alcohol Use: θ Never θInfrequent 1-2 per wk θ Moderate 3-5 per wk θHeavy 6+ per wk

Caffeine Use: θ Never θInfrequent 1-2 per wk θ Moderate 3-5 per wk θHeavy 6+ per wk

Drug/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.

θ Heart Disease	M	F	θ Back Problems	M	F
θ High Blood Pressure	M	F	θ Migraines	M	F
θ Lung Problems	M	F	θ Epilepsy/Seizures	M	F
θ Arthritis	M	F	θ Allergies/Asthma	M	F
θ Diabetes	M	F	θ Cancer	M	F

Patient/Guardian Signature ____ **Date**___________________