

Dr. Mitchell D. Simon
Chiropractic Physician
PATIENT HEALTH QUESTIONNAIRE

PERSONAL INFORMATION

Today's Date: _____ File #: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ____/____/____ Age: _____ Social Security #: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____-_____ Work: () _____-_____ ext. _____

Cell: () _____-_____ Email Address: _____

Occupation: _____ Employer: _____

Business Address: _____

Marital Status: S M D W Sex: M F Name of Spouse: _____

Who Referred You To Our Office Or How Did You Hear About Us? _____

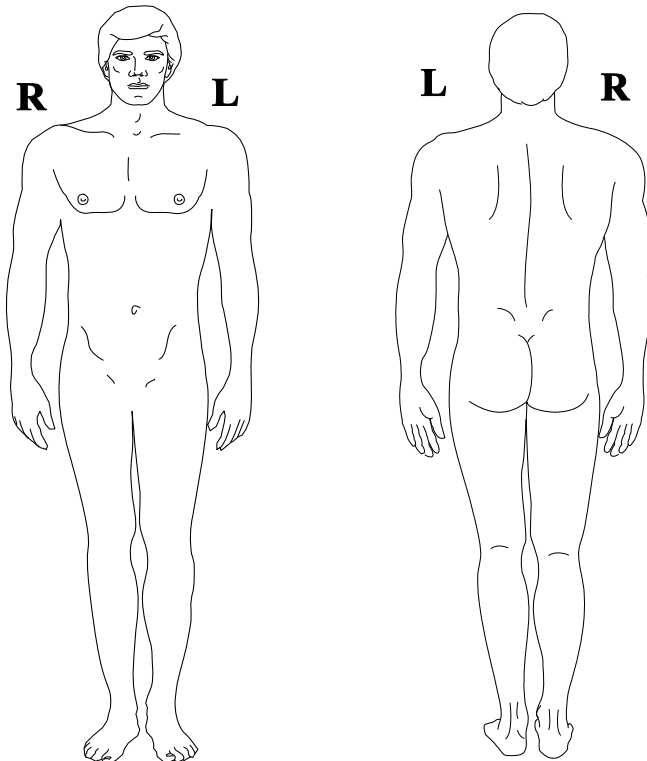
Have You Had Previous Chiropractic Care? No Yes; if so please indicate when and the doctors name: _____

Date of Your Last Physical Examination: ____/____/____ Primary Care Physician: _____

Are you: right handed left handed ambidextrous Address: _____

CURRENT COMPLAINTS

Pain Drawing: Please mark where and what type of pain you are currently experiencing. Use the symbols indicated to describe the type of pain or sensations you are feeling:



Use these symbols to describe the type of pain or sensations you are feeling:

>>> Aching pain

/// Stabbing or Sharp pain

XXX Burning pain

=== Numbness

ooo Pins and Needles

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Please list your complaints below with the most significant or primary complaint first:

1. **Area of Pain:** _____ **Frequency:** intermittent occasional frequent constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

2. **Area of Pain:** _____ **Frequency:** intermittent occasional frequent constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

3. **Area of Pain:** _____ **Frequency:** intermittent occasional frequent constant
Please **circle** the number which best describes the severity of your pain; 1 = no pain & 10 is unbearable pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

4. Other: _____

In general my symptoms are worse in: AM Midday PM; my symptoms do not change with the time of day.

Are your symptoms / condition: improving unchanged getting worse

HISTORY

Symptoms developed from: work injury car accident sports injury gradual unknown

The pain began on or about: _____. The pain is chronic and originally began on or about: _____

Describe how the symptoms began or what you think caused the symptoms / condition: _____

List other doctors you have seen for this complaint, the type of treatment given, and the result of that treatment: _____

Describe any past history of the same or similar complaint: _____

MEDICAL HISTORY

PATIENT HEALTH QUESTIONNAIRE

CHECK HERE IF YOU HAVE HAD OR ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

- | | | |
|--|---|--|
| <input type="checkbox"/> Blurring vision | <input type="checkbox"/> Buzzing or ringing in ears | <input type="checkbox"/> Headaches: Area of head: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness | How often: <input type="checkbox"/> daily <input type="checkbox"/> _____ times per day |
| <input type="checkbox"/> Loss of bowel or bladder function | <input type="checkbox"/> Confusion | <input type="checkbox"/> _____ times per week <input type="checkbox"/> _____ times per month |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Difficult Digestion | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Asthma | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Foot Trouble/Flat Feet | <input type="checkbox"/> HIV Positive |

Do you wake up with wide-spread muscular pain? _____

Do you have a pacemaker? Yes No

Please list any serious illness or medical conditions you have had and associated treatment:

Please list the name and address of other health practitioners & any specialist you have seen:

SURGICAL HISTORY

Please list any surgeries you have had; include date, type of surgery or for what condition and outcome:

FAMILY HISTORY

Please list any family history of heart disease, cancer, diabetes or other serious illness:

Women Only

Important - if you suspect you are currently pregnant, please notify the doctor immediately. X-rays should not be taken if you are pregnant!

Are you pregnant? Yes No Date of last menstrual cycle: _____ Do you have PMS? Yes No

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WORK HISTORY

How many hours do you normally work in a week? _____

In a typical workday, I: (circle the number of hours per day per activity)

Sit	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk	1	2	3	4	5	6	7	8	hours

On the job, I perform the following activities:

In terms of an 8-hour workday, "occasionally" = 33%, "frequently" = 34% to 66%, and "continuously" = 67% to 100% of the day.

	Not At All	Occasionally	Frequently	Continuously
Bend / Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing / Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check the category that best describes your work:

- Sedentary:** Lifting up to 10 lbs. maximum and occasionally lifting and / or carrying such articles as docket, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking is required only occasionally and other sedentary criteria are met.
- Light Work:** Lifting 20 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 10 lbs. Even though the weight lifting may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling or arm and / or leg controls.
- Medium Work:** Lifting 50 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 25 lbs.
- Heavy Work:** Lifting 100 lbs. maximum with frequent lifting and / or carrying of objects weighing up to 50 lbs.
- Very Heavy Work:** Lifting objects in excess of 100 lbs. with frequent lifting and / or carrying of objects weighing 50 lbs. or more.

SOCIAL HISTORY

Do you smoke? No Yes; if yes, how many packs of cigarettes do you smoke per day? _____

How many cups of coffee or caffeinated drinks do you have per day? _____

Do you consume alcohol? No Yes; if yes, would you say that your use of alcohol is occasional frequent or daily. Would you say your consumption of alcohol is light, medium, or heavy?

Do you have a regular program of exercise? No Yes, if yes, please note the frequency and type of exercise that you do:

List any hobbies or recreational sports / activities you enjoy doing:

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HEALTH INSURANCE INFORMATION

Name of Insured _____

Name of Insurance Co. _____

Address _____

Policy # _____ Telephone # _____

Spouse Insurance Co. _____

Address _____

Policy # _____ Telephone # _____

PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS ARE MADE!

Name of Person responsible for payment _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the release of any and all information you deem appropriate concerning my physical condition and treatment to any insurance company, attorney or adjuster in order to process claims for reimbursement of chiropractic charges incurred by me. I give my chiropractor power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree any services rendered to me are charged directly to me and that I am personally responsible for payment; including those resulting from my failure to obtain a necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original. I hereby irrevocably authorize the direct payment from the insurance company to my chiropractor any sum I now or hereafter owe for my chiropractic treatment. I understand and agree a credit history may be initiated by my chiropractor to determine my credit worthiness and/or if I am delinquent in paying my bill. I agree to pay all attorney fees incurred by my chiropractor in the collection of any account balance. 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.

Patient's Signature: _____ **Date:** ____/____/____

Guardian or Spouse's Signature _____ **Date:** ____/____/____

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FILL THIS SECTION OUT IF YOUR INJURY IS RELATED TO AN AUTO ACCIDENT

Date of accident: _____ Hour: _____ AM PM

Were you the driver passenger: front seat back seat; pedestrian. Were the roads dry wet snowy.

Were you struck from behind driver's side passenger's side head on. Were you wearing a seat belt Yes No

Do you recall any part of your head or body striking any part of the interior of the car? Yes No

If yes, please describe: _____

Type of vehicle you were in? _____ Type of vehicle that struck you? _____

Were you aware of the impending collision? _____

Head / body position at time of impact:

- | | | |
|--|---|--|
| <input type="checkbox"/> head turned to left / right | <input type="checkbox"/> head looking back | <input type="checkbox"/> head straight forward |
| <input type="checkbox"/> body straight in sitting position | <input type="checkbox"/> body rotated to left / right | <input type="checkbox"/> other: _____ |

Did you feel pain immediately gradually next day other: _____

Were you knocked unconscious? Yes No. Did you receive first aid? Yes No

Did you go to the hospital by ambulance, a friend, or did you drive yourself.

Name of hospital: _____

Did the hospital take x-rays? Yes No. What treatment was given? _____

Have you been unable to work because of the accident? No Yes; if yes since when: ____/____/____

Have you consulted an attorney? No Yes; if yes please give name, address, and phone: _____

FILL THIS SECTION OUT IF YOUR INJURY IS RELATED TO A WORK ACCIDENT

Date of accident: ____/____/____ Hour: _____ AM PM

Did you report the accident to your supervisor within 48 hours? Yes No

Did a fellow employee witness the accident? Yes No

Have you been unable to work because of the accident? No Yes; if yes since when: ____/____/____

Have you consulted an attorney? No Yes; if yes please give name, address, and phone: _____