

**RE-ENTRY PATIENTS**

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_ Cell # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status S M D  
 e.mail address \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Person Responsible for this Account \_\_\_\_\_ HealthPlan \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

***Please describe your current problem.***

***Date problem began*** \_\_\_/\_\_\_/\_\_\_

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How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

How often are your symptoms present?       Constantly       Frequently       Occasionally       Intermittently

Describe your current pain/symptoms:       Sharp/Stabbing       Throbbing       Aches  
     Dull       Soreness       Weakness  
     Numbness       Shooting       Gripping  
     Burning       Tingling       Other \_\_\_\_\_

Since it began, is your problem:       Improving       Getting Worse       No Change  
 What makes the problem better?       Nothing       Lying Down       Walking  
     Standing       Sitting       Movement  
     Exercise       Inactivity/rest       Other \_\_\_\_\_

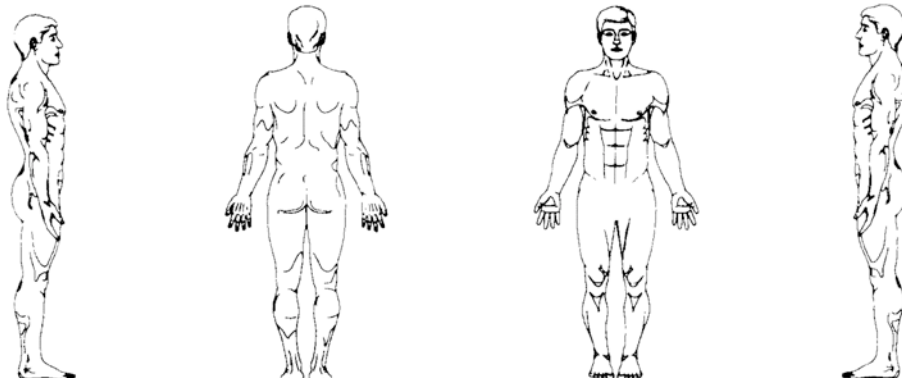
What makes the problem worse?       Nothing       Lying Down       Walking  
     Standing       Sitting       Movement  
     Exercise       inactivity/rest       Other \_\_\_\_\_

Can you perform your daily home activities?       Yes       Yes, only with help       Not at all  
 Do you exercise?       Yes, almost daily       Yes, occasionally       Not at all  
 Describe your job requirements:       Mainly sitting       Light Labor       Heavy Labor  
 Can you perform your daily work activities?       Yes, all activities       Only some       Not at all  
 Describe your stress level:       None to mild       Moderate       High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

Have you had X-rays, MRI or other tests for this condition? What tests and When? \_\_\_\_\_

**MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING**



Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Athens Chiropractic Clinic

# Patient Health Questionnaire

Patient Name \_\_\_\_\_ Patient ID# \_\_\_\_\_

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

<b>Past</b>	<b>Present</b>	<b>Condition</b>	<b>Past</b>	<b>Present</b>	<b>Condition</b>
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (date)_____
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date)_____
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain_____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain_____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
	<input type="checkbox"/>	Gain <input type="checkbox"/> Loss <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Other_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<b>If a family member has had any of the following, please mark the appropriate box:</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstral Flow	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstral Flow	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems
<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure_____
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	Do you have a permanent disability rating? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	Location_____		
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	Date rating received_____		
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	Rating Percentage_____		
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits	<b>Present Weight</b> _____pounds		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing	<b>Height</b> _____feet _____inches		
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash	<input type="checkbox"/>		
<b>Please check any of the following that apply to you.</b>					
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # births_____	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills, type_____	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere)	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffinated Soft drinks: cups/cans per day:_____

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 or health plan coverages in the future.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Treating Chiropractor: *Athens Patrignani Gutierrez*

Do you have Health Insurance? *Yes No*

Insurance Company Name \_\_\_\_\_

Do you have Chiropractic Benefits on your plan? *Yes No Uncertain*

Subscriber's Name \_\_\_\_\_ I.D. # \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Relationship to Subscriber: *Self Spouse Dependent Other* \_\_\_\_\_

I clearly understand and agree that I am responsible for payment of any and all services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Patients with group or individual insurance are responsible for any unpaid balance in the event their insurance either does not cover chiropractic or is terminated during treatment. I accept full responsibility for treatment and I release ATHENS CHIROPRACTIC CLINIC and it's doctors from any and all liability in the unlikely event that a problem occurs from my treatment. I, the undersigned, affirm that the above is true and correct, and consent to chiropractic care in this office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Guardian Must sign for all patients 17 years old or younger)

***(staff use only)***

**Received copy of Patient's Insurance Card?** *Yes No* **Staff Init.** \_\_\_\_\_

**Gave A.C.N. Paperwork?** *Yes No* **Staff Init.** \_\_\_\_\_

**A.C.N. Paperwork Completed?** *Yes No* **Staff Init.** \_\_\_\_\_

<b>DIAGNOSIS:</b>	<b>PATIENT #</b> _____	<b>ACCT. DATE</b> _____
_____	<b>Dr.:</b> Athens Patrignani Gutierrez	
_____	<b>Class:</b> Cash PI WC PPO MC	
_____	<b>Referral Type:</b> Pt. RE Staff Fair Other	