Parchem Chiropractic Center

Dr. Chad M. Parchem

PATIENT ADMITTANCE FORM-CONFIDENTIAL INFORMATION

Name_____ Birthdate_____

Address_____ City_____ Zip_____

E-mail _____ Phone_____

How did you find/hear about our office?_____

Occupation_____

Signature of Patient _____Date_____

Signature of Parent or Guardian _____Date_____

(Anyone under the age of 18 must have parent or guardian's signature before treatment can be rendered)

Patient Health Questionnaire-PHQ *Parchem Chiropractic Center*

1. Describe your symptoms _____

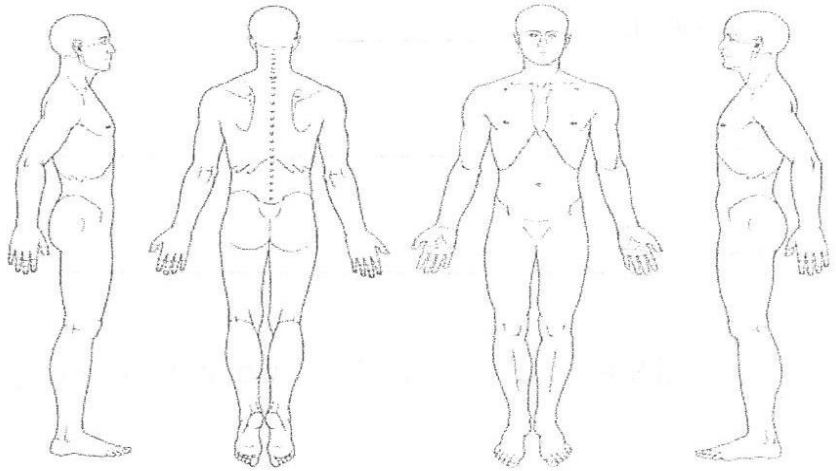
_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience symptoms? Indicate where you have pain or symptoms:

a. Constantly (75-100% of the day)
b. Frequently (50-75% of the day)
c. Occasionally (25-50% of the day)
d. Intermittently (0-25% of the day)



3. What describes your symptoms?

a. Sharp d. Shooting
b. Dull Ache e. Burning
c. Numb f. Tingling

4. Does the pain travel into:

a. Arms c. Legs e. none
b. Fingers d. Toes

5. How are your symptoms changing?

1. Getting better
2. Not changing
3. Getting worse

6. Does anything make the symptoms worse?_____

7. Does anything make the symptoms better?_____

8. During the <u>past 4 weeks</u>:

a. Indicate the average intensity of your symptoms (Circle One) None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

b. How much has the pain interfered with your normal work and your normal everyday routines?
1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

9. Who have you seen for your symptoms? 1. No one 2. Other Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed? 1. Xrays date: _____ 2. MRI date: _____ 3. CT Scan date: _____ 4. Other date: _____

10. Have you had similar symptoms in the past? 1. Yes 2. No

a. If you have received treatment in the past for the same or similar symptoms, who did you see? 1. This Office 2. Other Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

Patient Signature_____ Date_____