PATIENT INTRODUCTION

ATTLEBORO CHIROPRACTIC HEALTH CENTER
Dr. Terrence G. Aussant
3 MILL STREET. ATTLEBORO, MA. 02703
PHONE 508.431.2920 FAX 508.431.2925

Date: ________________
(fecha de hoy)

Full Name:____ **SS#** ___________________
(Nombre Completo) *(Social Security)*

Age: _____ **Date of Birth:**_____________ **Gender:** ❑M ❑F **Marital Status:** ❑S ❑M ❑D ❑W
(Edad) *(Fecha de Nacimiento)* *(Sexo)* *(Estado Civil)*

Address____
(Direccion)

City____________________________ **State**______ **Zip Code**__________
(Ciudad) *(Estado)* *(Area)*

Home Phone # ____________________ **Cell Phone #** ___________________
(Telephono)

E-Mail:____

Occupation____ **For How Long?** _______________
(Ocupacion) *(Hace cuanto tiempo)*

Employer____ **Employer Phone #** _____________
(Compania) *(Telefono del Trabajo)*

Emergency Contact ___________________________________ **Phone #** ______________________

Primary Care Physician _______________________________ **City** _________________________

How were you referred to this office? ____

Name of Health Ins:_______________________________ **Subscriber:**_______________________________

Subscriber's D.O.B._______________ **Subscriber's Employer:**_____________________________________

PATIENT HEALTH QUESTIONNAIRE ATTLEBORO CHIROPRACTIC HEALTH CENTER, INC.

Name: ___________________________________

Describe your symptoms ____

____

____

When did your symptoms start? ____

How did your symptoms begin? ____

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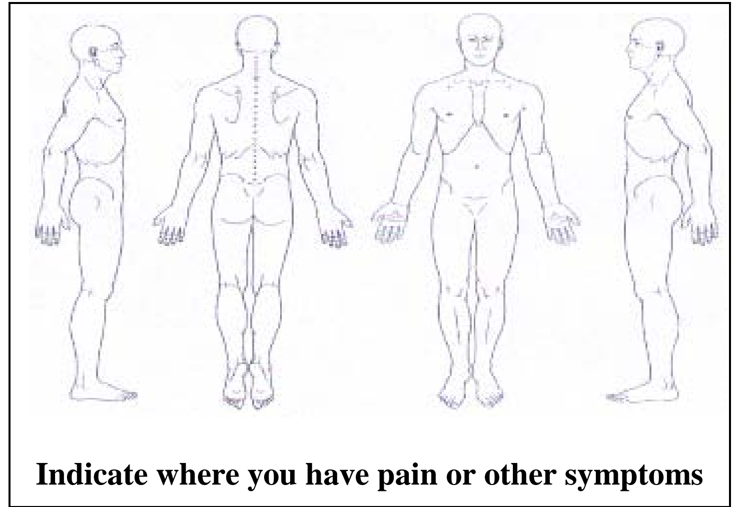
How often do you experience these symptoms?
- ❑ Constant (76-100% of the day)
- ❑ Frequent (51-75% of the day)
- ❑ Intermittent (26-50% of the day)
- ❑ Occasional (0-25% of the day)



Indicate where you have pain or other symptoms

Describe the nature of your symptoms?
❑ Sharp ❑ Dull ache ❑ Numb
❑ Shooting ❑ Burning ❑ Tingling
❑ Other ________________________

How are your symptoms changing?
- ❑ Getting Better
- ❑ Not Changing
- ❑ Getting Worse

Rate your pain (at best and worst) None ❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 Unbearable

What activities make your symptoms worse?____

What activities make you symptoms better? ____

Do you experience fever or chills? ❑ Yes ❑ No **Does the pain affect your sleep?** ❑ Yes ❑ No

Are there any changes in bowel or bladder function? ❑ Yes ❑ No

Who have you seen for your present complaint? ❑ No One ❑ Medical Doctor ❑ Chiropractor ❑ Physical Therapist ❑ Other: ______________

What tests were performed? ❑ X-ray ❑ MRI ❑ CT Scan ❑ Other

Have you had similar symptoms in the past? ❑ Yes ❑ No

What treatment did you receive? ____

Have you lost time from work or school? ❑ Yes ❑ No

If Yes, How much time? ____

Have you returned to work/school? ❑ Yes ❑ No ❑ Full Duty ❑ Light Duty

What do you hope to get from your treatment? (select all that apply)
❑ Reduce symptoms ❑ Explanation of condition/treatment
❑ How to prevent future episodes ❑ Resume/Increase activity ❑ ____________________________

Patient Signature: ____ Date: _______________________

PATIENT HEALTH QUESTIONNAIRE #2

Patient Name ____ **Date** _____________

What type of regular exercise do you perform? ❑None ❑Light ❑Moderate ❑Strenuous

What is your height and weight? _____feet _____inches _____lbs.

For each of the conditions listed below, place a check in the PAST column if you had the condition in the past. If you presently have a condition listed below, place a check in the PRESENT column.

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	High blood Pressure	❑	❑	Diabetes
❑	❑	Neck Pain	❑	❑	Heart Attack	❑	❑	Excessive Thirst
❑	❑	Upper Back Pain	❑	❑	Chest Pain	❑	❑	Frequent Urination
❑	❑	Mid Back Pain	❑	❑	Stroke			
❑	❑	Low Back Pain	❑	❑	Angina	❑	❑	Tobacco Use
						❑	❑	Alcohol Use
❑	❑	Shoulder Pain	❑	❑	Kidney Stones			
❑	❑	Elbow/Upper arm Pain	❑	❑	Kidney Disorders	❑	❑	Allergies
❑	❑	Wrist Pain	❑	❑	Bladder Infection	❑	❑	Depression
❑	❑	Hand Pain	❑	❑	Painful Urination	❑	❑	Systemic Lupus
			❑	❑	Loss of Bladder Control	❑	❑	Epilepsy
❑	❑	Hip/Upper leg Pain	❑	❑	Prostate Problems	❑	❑	Dermatitis/Eczema/Rash
❑	❑	Knee/Lower Leg Pain				❑	❑	HIV/AIDS
❑	❑	Ankle/Foot Pain	❑	❑	Abnormal Weight Loss/Gain			
			❑	❑	Loss of Appetite			
❑	❑	Jaw Pain	❑	❑	Abdominal Pain	**Females Only**		
			❑	❑	Ulcer	❑	❑	Birth Control Pills
❑	❑	Joint Swelling/Stiffness	❑	❑	Hepatitis	❑	❑	Hormonal Replacement
❑	❑	Arthritis	❑	❑	Liver Disorders	❑	❑	Pregnancy
❑	❑	Rheumatoid Arthritis	❑	❑	Gall Bladder Disorders			
❑	❑	General Fatigue	❑	❑	Cancer	**Other Health Issues**		
❑	❑	Muscular Incoordination	❑	❑	Tumor	❑	❑	____________________
❑	❑	Visual Disturbance	❑	❑	Asthma	❑	❑	____________________
❑	❑	Dizziness	❑	❑	Chronic Sinusitis	❑	❑	____________________

Indicate if an immediate family member has had any of the following:

❑ Rheumatoid Arthritis ❑Heart Problems ❑Diabetes ❑Cancer ❑Other____________________

List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:

____

____

List any prior surgeries with their dates:

____

____

SIGNATURE:____ **DATE:**_____________

NOTES: ____

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