PATIENT INTRODUCTION

ATTLEBORO CHIROPRACTIC HEALTH CENTER
Dr. Terrence G. Aussant
175 NORTH MAIN 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 _____ **Phone #**_____

Primary Care City or Town _____

How were you referred to this office? _____

Name of Health Ins:_____ **Subscriber:**_____

Subscriber's D.O.B._____ **Subscriber's Employer:**_____

OFFICE USE ONLY_____

INS NAME:_____ INS NAME:_____ INS NAME:_____

ID #:_____ ID #:_____ ID #:_____

COPAY_____ COPAY_____ COPAY_____

OF VISITS_____ # OF VISITS_____ # OFVISITS_____
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PATIENT HEALTH QUESTIONNAIRE

ATTLEBORO CHIROPRACTIC HEALTH CENTER, INC.

Name: _____

Describe your symptoms _____

_____

_____

When did your symptoms start? _____

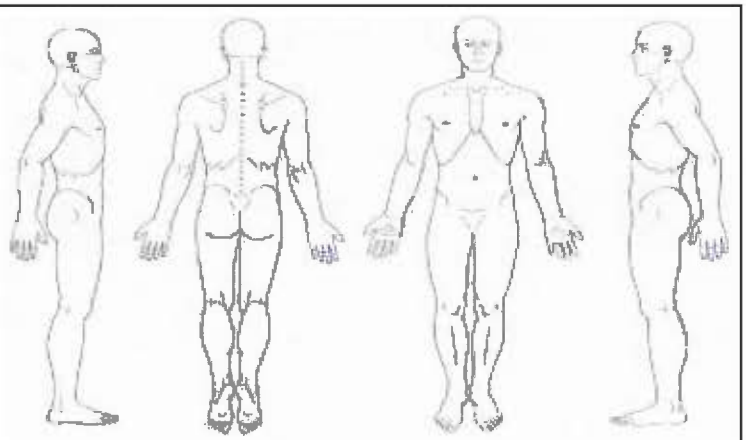
How did your symptoms begin? _____

_____

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)

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



Indicate where you have pain or other symptoms

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: _____

_____