Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Middle Name**_____

Last Name _____ **Nick Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Social Security Number _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued …

Verification Question *(choose only one question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the question: (Answer must be 6+ characters)_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications: including dosage, times per day taken, quantity of bottle, and form of med (tablet, capsule, liquid.)
If there are no current medications, check here: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

List any known allergies you have had to any medications. Include your reaction to the medication.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: (all health issues) _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

New Patient Information

Dr. Matthew Nelson Dr. Joel Sengbusch
Phone: (715) 386-9393 Fax: (715) 386-9885

Best Chiropractic: A Creating Wellness Center

NAME: _____ DATE: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELL#: _____ BEST TIME TO CONTACT: _____

E-MAIL ADDRESS: _____ SOCIAL SECURITY #: _____

MALE: _____ FEMALE: _____ BIRTH DATE: _____ AGE: _____

OCCUPATION : _____ EMPLOYER: _____

SINGLE: _____ MARRIED: _____ DIVORCED: _____ WIDOWED: _____

NUMBER OF CHILDREN: _____ NAMES, AGES AND GENDER: _____

HOW DID YOU HEAR ABOUT OUR OFFICE: _____

WHO CAN WE THANK FOR REFERRING YOU: _____

Insurance Company: _____

Relation to Policy Holder: Self Spouse Dependant

If NOT "Self" please fill out the following:

Name of policy holder: _____

Address: _____

Phone Number: _____

Date of Birth: _____

Social Security # (required): _____

New Patient Questionnaire

Dr. Matthew Nelson Dr. Joel Sengbusch
Phone: (715) 386-9393 Fax: (715) 386-9885

Patient Name: _____ Date: _____

Medical Condition:

___ Arthritis ___ Cancer ___ Diabetes
___ Heart Disease ___ Hypertension ___ Psychiatric Illness
___ Skin Disorder ___ Stroke ___ Other _____

Surgeries:

___ Appendectomy ___ Cardiovascular ___ Cervical Disc
___ Hysterectomy ___ Joint Replacement ___ Laminectomies
___ Other _____

Allergies:

___ Eggs ___ Fish / Shellfish ___ Milk / Lactose
___ Peanut ___ Soy ___ Sulfites
___ Wheat / Gluten ___ Other _____

Social History:

Caffeine used	___ not at all	___ occasionally	___ often
Chew tobacco	___ not at all	___ occasionally	___ often
Drink alcohol	___ not at all	___ occasionally	___ often
Exercise	___ not at all	___ occasionally	___ often
Experience stress	___ not at all	___ occasionally	___ often
Smoke per day	___ not at all	___ 1 pack or less	___ 1 pack ++
Wear seatbelts	___ not at all	___ usually	___ always

Family History:

___ Arthritis ___ Cancer ___ High Cholesterol
___ Diabetes ___ Heart Problems ___ High Blood Pressure
___ Psychiatric ___ Stroke ___ Thyroid

Substance Use:

Alcohol	___ Past	___ Present
Amphetamines	___ Past	___ Present
Barbiturates	___ Past	___ Present
Cocaine	___ Past	___ Present
Crystal Meth	___ Past	___ Present
Heroin	___ Past	___ Present
Marijuana	___ Past	___ Present

Male Children:

___ 0-6 years of age ___ 7-10 years of age ___ 11-18 years of age

Female Children:

___ 0-6 years of age ___ 7-10 years of age ___ 11-18 years of age

Occupational Activities:

___ Administration	___ Business Owner	___ Clerical / Secretarial
___ Computers	___ Construction	___ Child Care
___ Executive / Legal	___ Food Service Industry	___ Healthcare
___ Equipment Operator	___ Heavy Manual Labor	___ Home Services
___ Household	___ Light Manual Labor	___ Manufacturing
___ Military	___ Medium Manual Labor	___ Police / Fire
___ Professional Services	___ Retail Worker	___ Teacher
___ Truck Driver	___ Other _____	

Recreational Activities:

___ Backpacking	___ Biking	___ Boating
___ Football	___ Golf	___ Racket Ball
___ Running	___ Skiing	___ Soccer
___ Swimming	___ Tennis	___ Walking
___ Weight Lifting	___ Bowling	___ Other _____

Have you had trouble with any of the following?

Cardiovascular:

Poor Circulation	___ Present	___ Past	___ No
High Blood Pressure	___ Present	___ Past	___ No
Aortic Aneurism	___ Present	___ Past	___ No
Heart Disease	___ Present	___ Past	___ No
Vascular Disease	___ Present	___ Past	___ No
Heart Attack	___ Present	___ Past	___ No
Chest Pain	___ Present	___ Past	___ No
High Cholesterol	___ Present	___ Past	___ No
Pace Maker	___ Present	___ Past	___ No
Jaw Pain	___ Present	___ Past	___ No
Irregular Heartbeat	___ Present	___ Past	___ No
Swelling of Legs	___ Present	___ Past	___ No

Genitourinary:

Kidney Disease	___ Present	___ Past	___ No
Lower Side Pain	___ Present	___ Past	___ No
Burning Urination	___ Present	___ Past	___ No
Frequent Urination	___ Present	___ Past	___ No
Blood in Urine	___ Present	___ Past	___ No
Kidney Stone	___ Present	___ Past	___ No

Hematologic/Lymphatic:

Hepatitis	___ Present	___ Past	___ No
Blood Clots	___ Present	___ Past	___ No
Cancer	___ Present	___ Past	___ No
Easy Bruising	___ Present	___ Past	___ No
Easy Bleeding	___ Present	___ Past	___ No
Fever/Chill/Sweat	___ Present	___ Past	___ No

Respiratory:

Asthma	___ Present	___ Past	___ No
Tuberculosis	___ Present	___ Past	___ No
Shortness of Breath	___ Present	___ Past	___ No
Emphysema	___ Present	___ Past	___ No
Cold/Flu	___ Present	___ Past	___ No
Cough/Wheezing	___ Present	___ Past	___ No

Ears/Nose/Throat:

Dizziness	___ Present	___ Past	___ No
Hearing Loss	___ Present	___ Past	___ No
Sinus Infection	___ Present	___ Past	___ No
Nosebleed	___ Present	___ Past	___ No
Sore Throat	___ Present	___ Past	___ No
Difficulty Swallowing	___ Present	___ Past	___ No
Bleeding Gums	___ Present	___ Past	___ No

Eyes:

Glaucoma	___ Present	___ Past	___ No
Double Vision	___ Present	___ Past	___ No
Blurred Vision	___ Present	___ Past	___ No

Integumentary:

Skin Lesions	___ Present	___ Past	___ No
Skin Ulcers	___ Present	___ Past	___ No
Skin Disease	___ Present	___ Past	___ No
Eczema	___ Present	___ Past	___ No
Psoriasis	___ Present	___ Past	___ No
Rashes	___ Present	___ Past	___ No

Allergic/Immunologic:

Hives	___ Present	___ Past	___ No
Immune Disorder	___ Present	___ Past	___ No
HIV/AIDS	___ Present	___ Past	___ No
Allergy Shots	___ Present	___ Past	___ No
Cortisone Use	___ Present	___ Past	___ No

Gastrointestinal:

Galbladder Problems	___ Present	___ Past	___ No
Bowel Problems	___ Present	___ Past	___ No
Constipation	___ Present	___ Past	___ No
Liver Problems	___ Present	___ Past	___ No
Ulcers	___ Present	___ Past	___ No
Diarrhea	___ Present	___ Past	___ No
Nausea/Vomiting	___ Present	___ Past	___ No
Bloody Stools	___ Present	___ Past	___ No
Poor Appetite	___ Present	___ Past	___ No

Musculoskeletal:

Gout	___ Present	___ Past	___ No
Arthritis	___ Present	___ Past	___ No
Joint Stiffness	___ Present	___ Past	___ No
Muscle Weakness	___ Present	___ Past	___ No
Osteoporosis	___ Present	___ Past	___ No
Broken Bones	___ Present	___ Past	___ No
Joints Replaced	___ Present	___ Past	___ No

Endocrine:

Thyroid Disease	___ Present	___ Past	___ No
Diabetes	___ Present	___ Past	___ No
Hair Loss	___ Present	___ Past	___ No
Menopausal	___ Present	___ Past	___ No
Menstrual Problems	___ Present	___ Past	___ No

Psychiatric:

Depression	___ Present	___ Past	___ No
Anxiety Disorder	___ Present	___ Past	___ No
Unusual Stress	___ Present	___ Past	___ No

Constitutional:

Weight Loss/Gain	___ Present	___ Past	___ No
Energy Level Problem	___ Present	___ Past	___ No
Difficulty Sleeping	___ Present	___ Past	___ No

Neurological:

Babinski	___ Present	___ Past	___ No
Stroke	___ Present	___ Past	___ No
Seizures	___ Present	___ Past	___ No
Head Injury	___ Present	___ Past	___ No
Brain Aneurysm	___ Present	___ Past	___ No
Numbness	___ Present	___ Past	___ No
Severe Headaches	___ Present	___ Past	___ No
Pinched Nerves	___ Present	___ Past	___ No
Parkinson's Disease	___ Present	___ Past	___ No
Carpal Tunnel	___ Present	___ Past	___ No
Spinning/Balance	___ Present	___ Past	___ No
Concussion	___ How Many	___ When Occurred	

Current Medications: _____

Vitamins / Supplements: _____

Do you wear orthotics or heel lifts? ___ Yes ___ No

I consent to a complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service is due at the time of service.

Signature: _____ Date: _____

Patient Health Questionnaire - PHQ

Revised 08/2011

Patient Name _____ Date _____

1. Describe your symptoms _____

_____

2. Date of symptom onset _____

3. How did your symptoms begin? _____

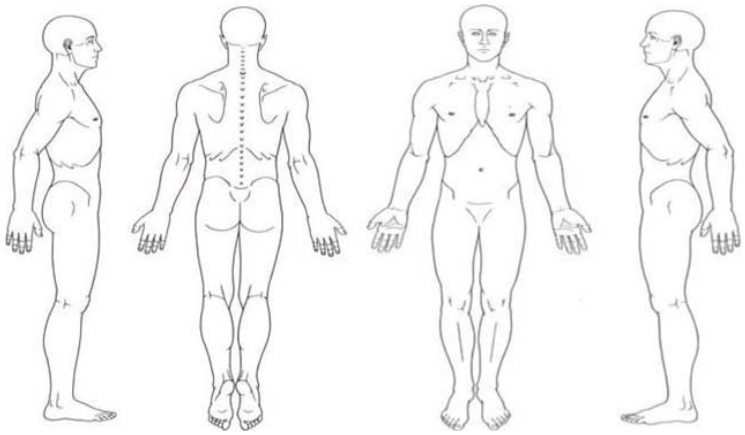
4. How often do you experience your symptoms?

(1) Constantly (76-100% of the day)
(2) Frequently (51-75% of the day)
(3) Occasionally (26-50% of the day)
(4) Intermittently (0-25% of the day)

5. Describe the nature of your symptoms:

(1) Sharp (4) Shooting
(2) Dull ache (5) Burning
(3) Numb (6) Tingling

Indicate below where you have pain or other symptoms:



6. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

7. How much have your symptoms interfered with your usual daily activities? (Including both work and home)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

8. How much of the time has your condition interfered with your social activities?

(1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time

9. How is your condition changing since care began at this facility?

(0) N/A - First visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

10. In general would you say your overall health right now is…

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

11. Who have you seen for your symptoms? (1) No one (2) Chiropractor (3) Medical Doctor (4) Physical Therapy (5) Other

12. What treatment did you receive and when? (ex: adjustment, physical therapy, medication, surgery, other)

_____ Date(s): _____

13. What tests have you had and when were they performed? (ex: X-rays, MRI, CT scan, other)

_____ Date(s): _____

14. Have you had similar symptoms in the past? ☐ Yes ☐ No If "yes", who did you see for treatment?

(1) This Office (2) Chiropractor (3) Medical Doctor (4) Physical Therapist (5) Other

15. What is your occupation? _____ Full-time or Part-time _____

Patient Signature _____ Date _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____