Sports Medicine / Joint Replacement
Shoulder Reconstruction / Podiatry / Physical Therapy

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PERSONAL INFORMATION

PATIENT NAME: ,	SS#:	DATE OF BIRTH:
ADDRESS:		ZIP CODE:
HOME #:	MOBILE #:	METHOD OF CONTACT: ☐PHONE ☐MOBILE ☐ EMAIL
DL #:	EMAIL:	MARITAL STATUS: ☐M ☐W ☐D ☐S
GENDER: ☐ M ☐ F	RACE:	ETHNICITY:
EMERGENCY CONTACT:	CONTACT #:	RELATION:

PATIENT EMPLOYMENT

EMPLOYER:	OCCUPATION:
EMPLOYER ADDRESS:	WORK #:
EMPLOYER TELEPHONE:	EMPLOYER FAX:

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

NAME:	SS#:	DOB:
ADDRESS:	PHONE #:	RELATIONSHIP:
EMPLOYER:	EMPLOYER TEL:	
FULL EMPLOYER ADDRESS:		

INSURANCE INFORMATION

☐WORKMAN'S COMP ☐GROUP ☐MEDICARE ☐CASH PAY

INSURANCE COMPANY:	
ID#:	GROUP#:
INSURED'S NAME:	INSURED DOB: / /
SECONDARY INS CO:	
SECONDARY INS ID#:	SECONDARY INS GRP#:
INSURED'S NAME:	INSURED DOB: / /

PATIENT/GUARDIAN SIGNATURE: ____ **DATE:** _____/_____/_____

****PLEASE PROVIDE A COPY OF ALL INSURANCE CARDS AND PHOTO**

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name ______________________ **Date** ______________________

1. Describe your symptoms ______________________

____

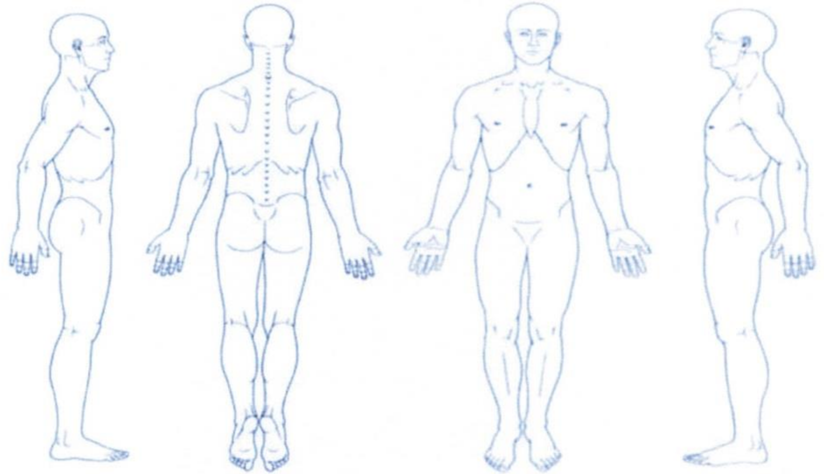
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. 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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

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

4. How are your symptoms changing?

(1) Getting Better
(2) Not Changing
(3) Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

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

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

(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

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

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

8. Who have you seen for your symptoms?

(1) No One (2) 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: __________ (3) CT Scan date: __________
(2) MRI date: __________ (4) Other date: __________

9. 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) Chiropractor (3) Medical Doctor (4) Physical Therapist (5) Other

10. What is your occupation?

(1) Professional/Executive (2) White Collar/Secretarial (3) Tradesperson (4) Laborer (5) Homemaker (6) FT Student (7) Retired (8) Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

(1) Full-time (2) Part-time (3) Self-employed (4) Unemployed (5) Off work (6) Other

Patient Signature ______________________ **Date** ______________________