Orthopaedic Specialists of Dallas
SPORTS MEDICINE • JOINT REPLACEMENT • FOOT/ANKLE SPECIALISTS

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1301 Summer Lee Drive, Rockwall, Texas 75032
T: 214.771.4400 F: 972.771.8103

## PATIENT DEMOGRAPHIC INFORMATION

| | | |
|---|---|---|
| Name: | SS#: | DOB: |
| Address: | | Zip Code: |
| Home #: | Mobile #: | Work #: |
| E-Mail: | | Marital Status: ☐ S ☐ M ☐ D ☐ W |
| Gender: ☐ M ☐ F | Race: | Ethnicity: |
| Emergency Contact/Relation: | | Phone #: |
| Employer: | Occupation: | |
| Primary Insurance: | Grp: | ID: |
| Primary Insured: | | DOB: |
| Secondary Insurance: | Grp: | ID: |
| Primary Insured: | | DOB: |
| Guarantor Name: | | Phone #: |
| Guarantor Address: | | Zip Code: |
| Referring Physician: | Primary Care Physician: | |
| Pharmacy/Phone/Address: | | |

PLEASE INDICATE MEDICATIONS YOU ARE CURRENTLY TAKING: (PLEASE INCLUDE PRESCRIBED, OVER THE COUNTER MEDICATIONS AND SUPPLEMENTS)

| MEDICATION | DOSAGE/STRENGTH | FREQUENCY | REASON |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

ARE YOU ALLERGIC TO ANY MEDICATIONS • IF YES, PLEASE INDICATE BELOW: YES ☐ NO ☐

| MEDICATION | REACTION |
|---|---|
| | |
| | |
| | |

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PAST MEDICAL HISTORY: (IF YOU HAVE BEEN DIAGNOSED WITH ANY ILLNESS BELOW CHECK THE APPROPRIATE BOX. LIST APPROXIMATE DATE OF DIAGNOSIS)

| ILLNESS | ✓ | DIAGNOSIS DATE | ILLNESS | ✓ | DIAGNOSIS DATE | ILLNESS | ✓ | DIAGNOSIS DATE |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | | | EPILEPSY/CONVULSIONS | | | MIGRAINES | | |
| ANEMIA | | | FREQUENT KIDNEY/ BLADDER INFECTIONS | | | MONONUCLEOSIS | | |
| ALCOHOLISM | | | FREQUENT LUNG INFECTIONS | | | MUMPS | | |
| ALLERGIES | | | GALBLADDER DISEASE | | | PNEUMONIA | | |
| ANOREXIA/BULEMIA | | | GALLSTONES | | | PSYCHIATRIC CARE | | |
| APPENDICITIS | | | GOUT | | | RHUEMATIC FEVER | | |
| ARTHRITIS | | | GLAUCOMA/ EYE DISEASE | | | OVARIAN/PROSTATE CANCER | | |
| ASTHMA | | | HEART DISEASE | | | RUBELLA | | |
| CANCER: | | | HEPATITIS: | | | STOMACH ULCERS | | |
| CHEMICAL DEPENDENCY | | | HIGH BLOOD PRESSURE | | | STD'S | | |
| CHICKEN POX/SHINGLES | | | HIGH CHOLESTEROL | | | STROKE/ANURISMS | | |
| CATARACT | | | HERNIA | | | THYROID PROBLEMS | | |
| DEPRESSION | | | KIDNEY DISEASE/ FAILURE | | | TONSILLITIS | | |
| DIABETES | | | LIVER DISEASE | | | TUBERCULOSIS | | |
| ESOPHAGEAL REFLUX | | | LUNG DISEASE | | | WHOOPING COUGH | | |
| EMPHYSEMA/COPD | | | MEASLES | | | SUBSTANCE ABUSE | | |

SURGICAL HISTORY: (PLEASE INCLUDE ANY OPERATIONS, HOSPITALIZATIONS OR PROCEDURES YOU HAVE HAD. PLEASE LIST DATE MM/YY.)

| SURGERY/PROCEDURE | DATE | DESCRIPTION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PATIENT/GUARDIAN PRINTED NAME:** _____

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

# 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** _____

_____

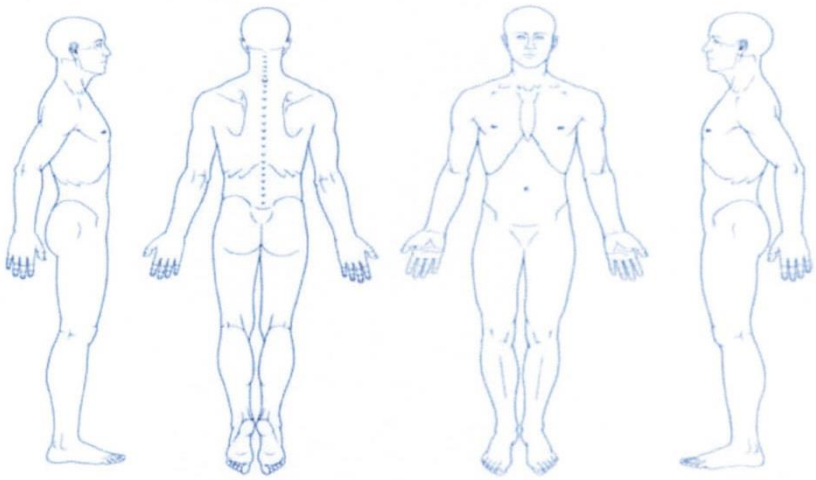
*a. When did your symptoms start?* _____

*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** _____