



Henrikson Chiropractic

Thank you for providing us with the following general information so that we may serve you better

Date: _____ Whom may we thank for referring you to us: _____

Patient Demographics

Patient Name: _____ DOB: _____ Sex: M/ F

What would you prefer to be called? _____

Marital Status: Married Single Other

Employment Status: Employed Full-Time Student Part-Time Student Retired

Occupation _____

Is condition due to an accident? _____

Type of accident _____

have you reported accident? Auto insurance Employer Worker Comp. Other _____

Provider Information

Referring Doctor: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Patient Contact Information

Address: _____

Home Phone: _____ Cell Phone: _____ City _____ State _____ Zip _____

E-mail: _____ Work Phone: _____

Communication Preference: _____

Employment Information

Employer Name: _____ Employer Phone: _____

Address: _____ City _____ State _____ Zip _____

Emergency Contact Information

Contact Name: _____ Relationship to Patient: _____

Contact Address: _____

Home Phone: _____ Cell Phone: _____ City _____ State _____ Zip _____

Work Phone: _____

Next of Kin

Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____



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Patient Health Questionnaire

Patient Name: _____

Date: _____

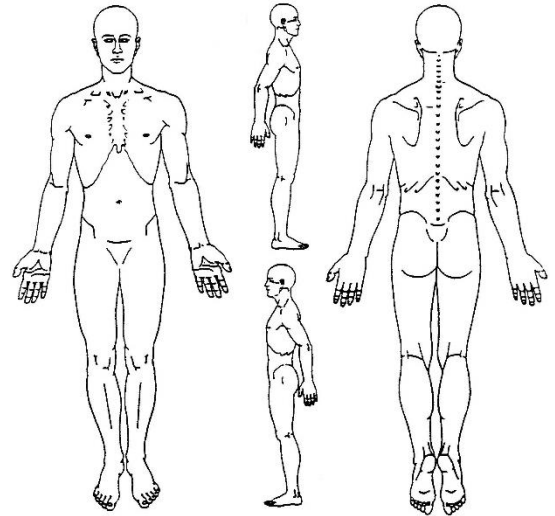
1. When did your symptoms start? _____
2. Describe your symptoms and how they began: _____

3. Are your symptoms the result of an injury, fall, accident? Yes No

4. How often do you experience your symptoms?

- a) Constantly (75-100% of the day)
- b) Frequently (51-75% of the day)
- c) Occasionally (26-50% of the day)
- d) Intermittently (0-25% of the day)

Please indicate where you have pain or other symptoms.



5. Describe the nature of your symptoms.

- a) Burning
- b) Dull ache
- c) Numb
- d) Sharp
- e) Shooting
- f) Tingling

6. How are your symptoms changing?

- a) Getting better
- b) Not changing
- c) Getting worse

7. During the past 4 weeks including both work outside the home and housework:

a) Indicate the average intensity of your symptoms.

- 0 1 2 3 4 5 6 7 8 9 10

b) How do your symptoms affect your ability to perform daily activities?

- 0 1 2 3 4 5 6 7 8 9 10



No Complaints Mild, forgotten with activity Moderate, interferes with activity Limiting, prevents full activity Intense, preoccupied with seeking relief Severe, no activity possible

8. What activities make your symptoms worse?

9. What activities make your symptoms better?

10. Have you had similar symptoms in the past? Yes No

11. What tests have you had for your symptoms?

X-rays date: _____ MRI date: _____ CT Scan date: _____ Other date: _____

12. Who have you seen for your symptoms? No one Other Chiropractor Medical Doctor PT Other

13. In the past 90 days, have you had (please check yes or no):

- a) Any loss of appetite Yes No
- b) Dizziness, Lightheadedness, or Fainting: Yes No
- c) Fevers, Chills, or Night Sweats: Yes No
- d) General Fatigue: Yes No
- e) Weight gain/loss of 10 pounds or more Yes No

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Patient Health Questionnaire

If you have ever had a symptom in the past listed below, check that symptom in the past column. If you are presently troubled by a particular symptom, check that symptom in the present column. This is a history of various systems of your body and knowledge of these conditions may influence the type of treatment, therapy, or referral you may receive.

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lump	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (Chronic Lung Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Stiffness of Joints
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (<input type="checkbox"/> Right, <input type="checkbox"/> Left)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain

Family History: if any of your immediate family members have/had the following, please mark the appropriate line.

	Mother	Father	Brother(s)	Sister(s)
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Failure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis/Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had surgery or been hospitalized? No Yes, Describe: _____

What medications are you currently taking? _____

Smoking History: Former Smoker Never Smoked Smoker, Frequency: _____

Do you drink alcohol? No Yes, Frequency: _____

Do you have or have had an alcohol, drug, or any other kind of addiction or dependence? Yes No

Patient Signature: _____

Date: _____