Johnson Chiropractic Inc.

Making Health a Way of Life!

ChiroCare Form PHQ-202

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	- 1

Patient Name			Date			
1. When did your symptoms start:		Describe your symptoms and how they began:				
2. How often do you experience	your symptoms?	Indicate where	you have p	ain or other symptoms		
① Constantly (76-100% of the		0	\bigcap	(36)	(0)	
Prequently (51-75% of the d		1.8-3	57	<u>﴾ (</u>	()	
③ Occasionally (26-50% of the		()	YE			
Intermittently (0-25% of the	day)	10) 1	1011	117411	(1)	
3. What describes the nature of	f vour symptoms?	that !	Marcalle	MY. YM	1-11"	
① Sharp ② Shooting		110 11	100	11 110.111	(6)	
② Dull ache ⑤ Burning		Gul Gul	1-1-1	m 900 1	in Course	
(3) Numb (6) Tingling		950	10/		1) an	
4. How are your symptoms cha	naina?).]	1-44-1	1.11.1	1.1	
	ngmy r		()()			
Getting Better Not Changing		1/	124	7,0,1	1/	
Getting Worse		le		207	3	
Setting Worse		None	40 00	25 19h	Unbearable	
5. How bad are your symptoms		vorst: 0 0	Ø 3	6 5 6 7 8 6 5 6 7 8	9 0	
6. How do your symptoms affect © ① ② No complaints Mild, forgotten with activity	3 0	6 (feres Limiting	ties? b (ii) prevents activity		Severe, no activity possible	
. What activities make your sy	mptoms worse:					
. What activities make your sy	mptoms better:					
. Who have you seen for your	symptoms?	No One Other Chiropre	actor	Medical DoctorPhysical Therapist	Other	
a. When and what treatment:	? -					
b. What tests have you had for	or vour symptoms	① Xrays date:		3 CT Scan date:		
and when were they performed?		② MRI date:		● Other date:		
0. Have you had similar sympt	oms in the past?	① Yes	② No		AA o o o o o o o o o o o o o o o o o o	
				6 W- P-10-1	0.01	
 a. If you have received treatn the same or similar symptoms 		This OfficeOther Chiropre	actor	Medical DoctorPhysical Therapist	6 Other	
11. What is your occupation?		① Professional/Executive		Laborer	@ Retired	
		White Collar/Secretarial		S Homemaker S Other		
		3 Tradesperson		6 FT Student		
a. If you are not retired, a hor student, what is your current		① Full-time ② Part-time		Self-employedUnemployed	Off work Other	
2. What do you hope to get fro	m your visit/treatm	ent (select all that	apply):			
Reduce symptoms Resume/increase activity	S Explanation of co Learn how to take	endition/treatment		 How to prevent this from 6	m occurring agair	
				Data		
atient Signature				Date		

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Patier	nt Name			Date			BP	1
	type of regular exercise do you p	erform?	① None	② Light		3 Moderate	Strer	uous
	is your height and weight?		Height			Weight		lbs.
· · · · · · · · · · · · · · · · · · ·	io your noight and troight.		Feet	Inches				
	ach of the conditions listed below presently have a condition listed					had the cond	lition in t	he past.
Past	Present	Past F	Present		Past	Present		
0	O Headaches	0	O High Blood Pressure		0	 Diabetes 	3	
0	O Neck Pain	0	O Heart Attack		0	 Excessive 		
0	O Upper Back Pain	0	O Chest Pains		0	 Frequent 	Urination	1
0	O Mid Back Pain	0	O Stroke		0	O Smoking	/Llea Toba	acco Products
0	O Low Back Pain	0	O Angina		0	O Drug/Alc		
0	O Shoulder Pain	0	O Kidney Stones			o Brugn to	onor Dopo	ondonoo
0	O Elbow/Upper Arm Pain	0	 Kidney Disorders 		0	 Allergies 		
0	O Wrist Pain	0	 Bladder Infection 		0	Depress		
0	O Hand Pain	0	O Painful Urination		0	 Systemic 		
0	O His Misses Lee Bais	0	O Loss of Bladder Contr	ol	0	 Epilepsy 		
0	Hip/Upper Leg PainKnee/Lower Leg Pain	0	O Prostate Problems		0	 Dermatit 		a/Rash
0	Ankle/Foot Pain	0	O Abnormal Weight Gai	n/Loss	0	O HIV/AID	S	
0	O Alikie/Poot Paili	0	O Loss of Appetite		Fem	ales Only		*
0	O Jaw Pain	0	O Abdominal Pain		0	O Birth Cor	trol Dille	
0	O Joint Swelling/Stiffness	0	O Ulcer		0	O Hormona		mont
0	O Arthritis	0	O Hepatitis		0	O Pregnand		ment
0	O Rheumatoid Arthritis	0	O Liver/Gall Bladder Dis	order	0	O	у	
				oraci				
0	O General Fatigue	0	O Cancer		Othe	er Health Pro	blems/lss	ues
0	Muscular Incoordination	0	O Tumor		0	0		
0	O Visual Disturbances	0	O Asthma		0	0		
0	O Dizziness	0	 Chronic Sinusitis 		PRI	EGNANT?	y or N	
						of PREGNA		
Indica	te if an immediate family member	r has had	d any of the following:		"			
OR	neumatoid Arthritis O Heart Prob	olems	O Diabetes O Ca	ncer	0	Lupus O_		
List al	l prescription and over-the-count	er medic	eations, and nutritional/	herbal su	plem	ents you are	taking:	
		***************************************				same and a second of		
List al	I the surgical procedures you hav	ve had a	nd times you have been	hospitali	zed:			
Patien	t Signature				Date			
	r's Additional Comments				2410			MARCONINCO CONTROL CON
D4-	ra Cianatura				Data			