Dakota Good Life Chiropractic, PC

121 E 28th St
South Sioux City, NE 68776
Phone: (402) 241-7497

Patient Confidential information

Name:_____

(Last) (First) (MI)

Address:_____

(Street) (City) (State) (Zip)

Phone:_____ E-mail: _____

Age:_____ Gender:_____ Date Of Birth: _____

Employer:_____ Job Title:_____

Marital Status: Married Single Divorced Widow/Widower (please circle one)

Spouse's name: _____ Number of Children: _____

Emergency contact name: _____ Relationship: _____

Emergency contact number: _____

Family Physician: _____

How did you hear about Dr. Nikole? _____

I understand that I am responsible for payment of any treatments/supplies/supplements at the time of service.

Date: _____

Patient or Guardian Signature: (Please indicate relationship to patient if applicable)

_____

Patient Health Questionnaire

Patient Name: _____ Date:_____

IS THIS A WORK RELATED/AUTO INJURY? YES_____ NO_____

1. When did your symptoms start?_____

Describe your symptoms and how they began?_____

2. Indicate where you have pain or other symptoms:
How often do you experience your symptoms?

a) Constantly (76-100% of the day)
b) Frequently (51-75% of the day)
c) Occasionally (26-50% of the day)
d) Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

- o Aching
- o Dull
- o Sore
- o Sharp
- o Shooting
- o Burning
- o Tingling
- o Numb
- o Stiff

4. How are you symptoms changing?

o Improving o Not changing o Getting worse

5. Rate your symptoms currently on the scale below: (0: meaning no pain; 10: meaning unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

6. 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, interfere with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse? _____

8. What activities make your symptoms better?_____

9. Who have you seen for your symptoms?

a. Other Chiropractor
b. Medical doctor
c. Physical Therapist
d. Other _____

Who did you see?_____

What treatment was performed? _____

Did you experience relief? _____

Were any test performed? Yes No If yes, what tests? _____

10. Have you ever experienced similar symptoms in the past? Yes No
If yes, who did you see at that time? _____

Past and current medical history

Previous surgeries? Yes No
If yes, what surgeries and when? _____
_____

Previous accidents or injuries? Yes No
If yes, what injuries and when? _____

Previous illnesses or hospitalizations? Yes No
If yes, what and when? _____

Current medications or supplements you're taking? Yes No
If yes, list them here: _____
_____

Do you drink alcohol? Yes No Former

If yes, number of alcoholic beverages per day?_____
If yes, how many years? _____

Are you a smoker? Yes No Former

If yes, how many packs/day? _____
If yes, how many years? _____

Do you exercise? Yes No Former

If yes, what type of exercise? _____
If yes, how often? _____

Circle if you, your parents, siblings, or children have any of the following conditions:

- o Rheumatoid Arthritis
- o Diabetes
- o Lupus
- o Heart Disease
- o High Blood Pressure
- o Stroke
- o Cancer
- o Epilepsy
- o Mental illness

If you selected any of the previous, please specify who has/had the condition:

_____

Women Only:

Are you currently pregnant? Yes No

If yes, when is the due date?_____

For each of the conditions listed below, please circle if YOU have had the condition in the past or currently:

Constitutional:
Appetite change
Bruises easily
Fever/Chills
Hot Flashes
Fatigue
Generalized weakness
Insomnia
Weight change
Other:_____

Allergies:
Seasonal
Drug
Animal
Environmental
Other:_____

Neurological:
Stroke
Dizzy spells
Balance problems
Numbness/tingling
Tremors
Leg/Arm weakness
Memory loss
Speech problems
Other:_____

Gastrointestinal:
Acid reflux
Indigestion/heartburn
Nausea/vomiting
Abdominal pain
Bloody/tarry stools
Abdominal cramps
Diarrhea
Constipation
Change bowel habits
Hemorrhoids
Ulcers
Gallbladder problems
Other:_____

Genitourinary:
Kidney Stones
Kidney disorders
Loss of Bladder Control
Painful/Frequent Urination
Bladder infection
Prostate Problems (Men only)
Other:_____

Cardiovascular:
Chest pain/angina
Edema/swelling
Hardening of arteries
Heart attack
Heart failure
Heart murmur
High blood pressure
Irregular heart beat
Low exercise tolerance
Mitral value prolapse
Pacemaker
Palpitations
Skipped heart beats
Swelling
Other:_____

Musculoskeletal:
Headaches
Neck pain
Upper back pain
Midback pain
Low back pain
Shoulder pain
Arm pain
Wrist pain
Hand pain
Leg pain
Hip pain
Knee pain
Ankle/foot pain
Jaw pain
Joint swelling
Arthritis
Scoliosis
Muscle cramps
Muscle weakness
Other:_____

Ear/Eyes/Nose/Throat:
Ear infection
Ringing in the ears
Blurred/double vision
Sinus problems
Bloody nose
Sore throat
Other: _____

Endocrine:
Diabetes
Pituitary disease
Thyroid disease
Excess thirst
Tired/sluggish
Heat/cold intolerance
Other:_____

Respiratory:
Asthma
Tuberculosis
Emphysema
Frequent cough
Shortness of breath
Wheezing
Other:_____

Hematological/Lymphatic:
Swollen glands
Bleeding problems
Hepatitis
HIV/(AIDS)
IV drug use
Sickle cell
Other:_____

Patient's signature: _____