

2726 Johnson Street N.E.
Minneapolis, MN 55418
(612)-789-1010
warnerchiropracticclinic.com



Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)

Gender

Female Male

Your Last Name

Your First Name

M.I.

Birth Date (MM/DD/YYYY)

Address

Marital Status

Married Divorced Single

Widowed Separated

City

State/Province

ZIP/Postal Code

Email Address

Cell Phone

We occasionally send out informational emails
as well as a newsletter, would you like to opt-in to receive them?

Yes, sign me up!

Work Phone

Emergency Contact (Name)

Your Employer

Emergency Contact (Phone Number)

Employer's Address

City

State/Province

ZIP/Postal Code

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Insured's First Name

Insured's DOB (MM/DD/YYYY)

Insured's Employer

Who carries this policy? Self Spouse Parent

Please Print Name: _____

Patient Health Questionnaire – PHQ

Patient Name _____ Date _____

Height _____ Weight _____ Occupation _____

Who may we thank for referring you? _____

1. What brings you in today? Please describe your symptoms.

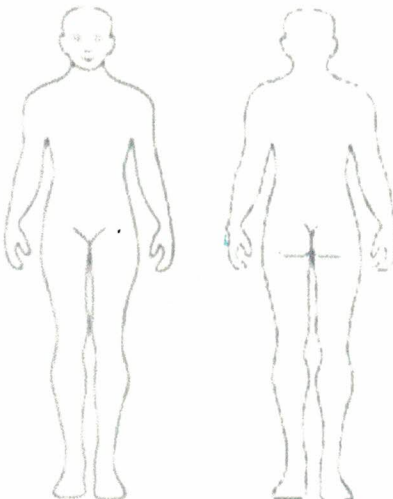
2. Please indicate how your symptom(s) began and the date of onset.

3. How intense are your symptoms? Please circle a number between 0-10.

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS INTENSE SYMPTOMS

4. Please circle the areas of the body where you have pain or other symptoms.



5. What does it feel like? Select all that apply.

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramping
- Nagging
- Sharp
- Shooting
- Burning
- Throbbing
- Stabbing
- Swelling
- Other

6. How often do you experience your symptoms?

Please Print Name: _____

7. How is this symptom/condition interfering with your life? Check where appropriate.

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Have you seen another provider for your symptoms? (circle answer)

a. Yes

i. If so, whom? _____ Date of treatment _____

b. No

9. Have you received previous chiropractic care? (circle answer)

a. Yes

i. Name of clinic _____ Phone Number _____

Were X-Rays taken? (circle answer) Yes No

b. No

10. Please list all prescription and over-the-counter medications, and nutritional/herbal supplements you are currently taking:

11. Please list any/all hospitalizations and/or surgical procedures you have had.

12. For each condition listed below, please indicate if you have experienced the condition in the past or if you currently experience the condition. Leave blank if not applicable.

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Wrist/Forearm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus

Past	Present	Past	Present	Past	Present			
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Oral Contraceptives
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Replacement Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Other

13. What are your health goals?

Please Print Name _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____