Patient Information

Name_____ Soc. Sec. # ___/___/_____ Date of Birth___/____/_____

Address_____City_____State_____Zip _____

Phones: Home _____ Work _____ Cell _____ Age_____ Sex: M F

Place of Business_____Address_____City_____State_____ Zip _____

Accident Related: Y N Auto Related: Y N Employment Related: Y N

Date of accident\injury_____/____/_____ State_____ Email Address: _____

Emergency Contact:

Name_____Relationship _____

Phones: Home_____/_____Work_____/_____ Cell_____/_____

Are you taking any medications? Y_____N_____If yes, what kind & why?

_____

_____

Have you had surgery in the past two years? If yes, please explain

_____

_____

Please check any of the following conditions that apply:

____ AIDS	____ Diabetes	____ Hand Numbness	____ Joint Replacement	____Pacemaker
____ Arthritis	____ Difficulty Swallowing	____ Headaches	____ Kidney Problems	____Pregnant
____ Asthma	____ Dizziness, fainting	____ Heart Condition	____ Knee Pain	____Sciatica
____ Back Injury	____ Edema	____ Hep A,B, C	____ Leg Pain	____Seizure Disorder
____ Bleeding Disorder	____ Fatigue	____ Hernia	____ Loss of Balance	____Stroke
____ Cancer	____ Foot Pain	____ Herniated Disk	____ Low Back Pain	
____ Chest Pain	____ Fractures	____ Hip Pain	____ Neck Pain	

Who is your referring doctor? _____

What treatment did you receive and when? _____ Date:_____/____/_____

What tests have you had for your symptoms and when were they performed?

① X rays Date:_____/____/_____ ③ CT Scan Date:_____/____/_____

② MRI Date:_____/____/_____ ④ Other Date:_____/____/_____

Have you had similar symptoms in the past? ① Yes ② No

If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Clinic ③ Medical Doctor ⑤ Other

② Chiropractor ④ Physical Therapist

What is your occupation?

① Professional/Exec ③ Tradespersons ⑤ Homemaker ⑦ Retired

② White collar/Sec'y ④ Laborer ⑥ FT Student ⑧ Other

*** CONTINUED ON BACK ***

Leading Edge - Patient Health Questionnaire

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 8/14/14

Patient Name_____ Date_____/_____/_____

Date symptoms began: _____/_____/_____

Describe your symptoms _____

How did your symptoms begin? _____

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)

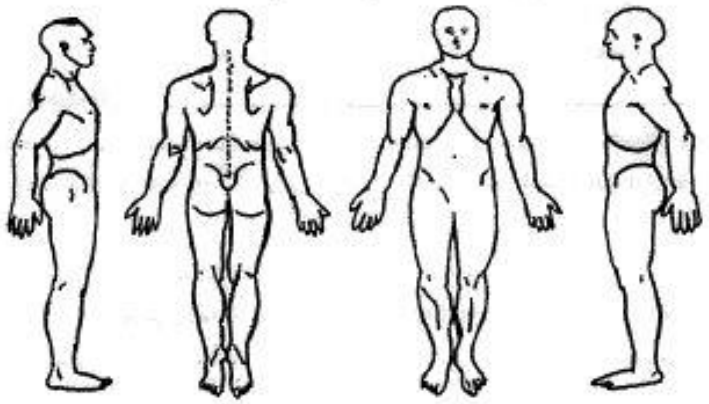
What describes the nature of your symptoms?

① Sharp
② Dull Ache
③ Numb
④ Shooting
⑤ Burning
⑥ Tingling

How is your condition changing, since care began at this facility?

⓪ N/A - This is my first visit
① Much worse
② Worse
③ A little worse
④ No change
⑤ A little better
⑥ Better
⑦ Much Better

Indicate where you have pain or other symptoms



Average pain intensity:

Last 24 hours: No pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst pain
Past week: No pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst pain

How much have your symptoms interfered with your usual daily activities?

Both work outside the home, and housework
① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

Visiting with friends, relatives, etc.
① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

Because a therapist must be aware of any existing physical conditions that I have, I have listed all my known medical conditions and physical limitations, and I will inform my therapist of any changes in my physical health. I understand that a therapist neither diagnoses illness, disease, or any other medical, physical, or mental disorder. I am responsible for consulting a qualified physician for any physical ailment that I have.

I hereby give permission to the therapists and staff of administer treatment and perform such general procedures, as they may deem necessary in the diagnosis and/or treatment of my condition.

Patient Signature:_____ **Date:**_____/_____/_____

*** PROVIDER COMPLETES THIS SECTION ***

Date you want *THIS* submission to begin:

Patient Type
① New to your office
② Est'd, new injury
③ Est'd, new episode
④ Est'd, continuing care

Nature of Condition
① Initial onset (within last 3 months)
② Recurrent (multiple episodes of < 3 months)
③ Chronic (continuous duration > 3 months)

Cause of Current Episode
① Traumatic
② Unspecified
③ Repetitive
④ Post-surgical
⑤ Work related
⑥ Motor vehicle

DC ONLY
Anticipated CMT Level
○ 98940 ○ 98941 ○ 98942 ○ 98943

Date of Surgery

Type of Surgery
① ACL Reconstruction
② Rotator Cuff/Labral Repair
③ Tendon Repair
④ Spinal Fusion
⑤ Joint Replacement
⑥ Other

Current Functional Measure Score

Neck Index ____ DASH ____
Back Index ____ LEFS ____
_____ (other) ____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° ☐☐☐.☐☐
2° ☐☐☐.☐☐
3° ☐☐☐.☐☐
4° ☐☐☐.☐☐