

SOPHIA A. ARGEROPOULOS, D.C., P.C.

Date: _____

PATIENT HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

Have you had previous Chiropractic care? YES NO

What is your major complaint/ injury? _____

Have you had any Diagnostic Imaging? YES NO Where?: _____

Are your injuries accident related? YES NO AUTO WORK OTHER: _____

When did you problem begin? _____

Since your symptoms began, they have: (circle all that apply)

Increased Decreased Stayed the same

Your symptoms are: Always present Frequent Occasional On and off

How bad is your pain or ache? 1 2 3 4 5 6 7 8 9 10

Describe your pain: Sharp Shooting Dull/Ache Stiff Tingling Numbness Burning

Throbbing Knife-Like Other _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Other Doctors who treated this condition? _____

List any surgeries: _____

Current Medications: _____

Allergies: _____

Have you been hospitalized in the last 5 years? YES NO When/Why? _____

Have you been diagnosed with Diabetes YES NO If yes, TYPE I TYPE II

EXERCISE: NONE MODERATE DAILY HEAVY

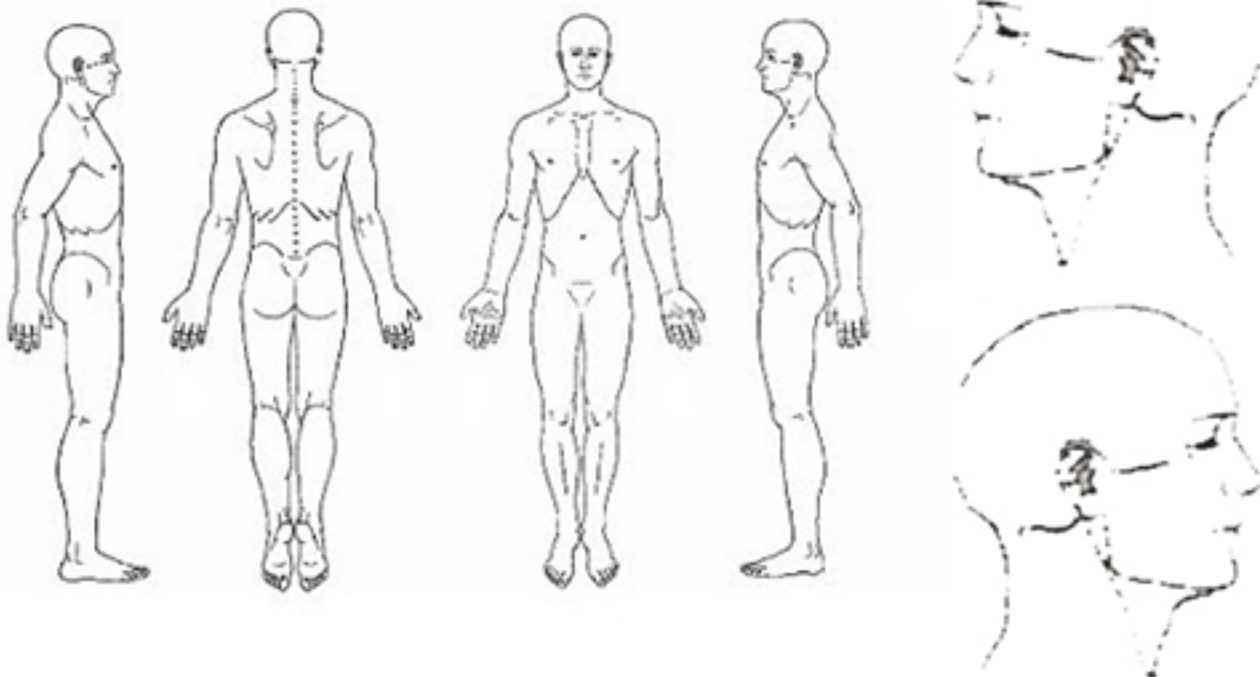
WORKACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR

HABITS: SMOKING ALCOHOL COFFEE/CAFFEINE DRINKS HIGH STRESS

Please check to indicate if you have any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Weight gain or loss | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blurry/Double vision | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ease of bruising |
| <input type="checkbox"/> Sinus pain | <input type="checkbox"/> Burning/Pain w/urination | <input type="checkbox"/> Nervousness/Anxiety |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Calf pain w/walking | <input type="checkbox"/> Prostrate issues |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Leg cramping | |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Seisures | |

Please mark your areas of discomfort:



INSURANCE INFORMATION:

******* Please provide Insurance card(s) and Driver's License or Photo ID *******

PRIMARY INSURANCE: _____ **POLICY #:** _____

NAME OF INSURED AND DATE OF BIRTH:: _____

INSURED EMPLOYER: _____

SECONDARY INSURANCE: _____ **POLICY #:** _____

NAME OF INSURED AND DATE OF BIRTH: _____

INSURED EMPLOYER: _____

We invite you to discuss with us any questions regarding our services. The best health services are based on friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services at time of visit, unless other arrangements have been made. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the provider to release any information required to process/secure insurance claims/benefits, and I assign all applicable insurance benefits directly to SOPHIA A. ARGEROPOULOS, D.C. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient or Legal Representative: _____

Date: _____

(Revised 09/2017-4)