Patient Health Questionnaire

Patient Name_____ ***Date***_____

1. When did your symptoms start?_____ ***Describe your symptoms and how they began:***

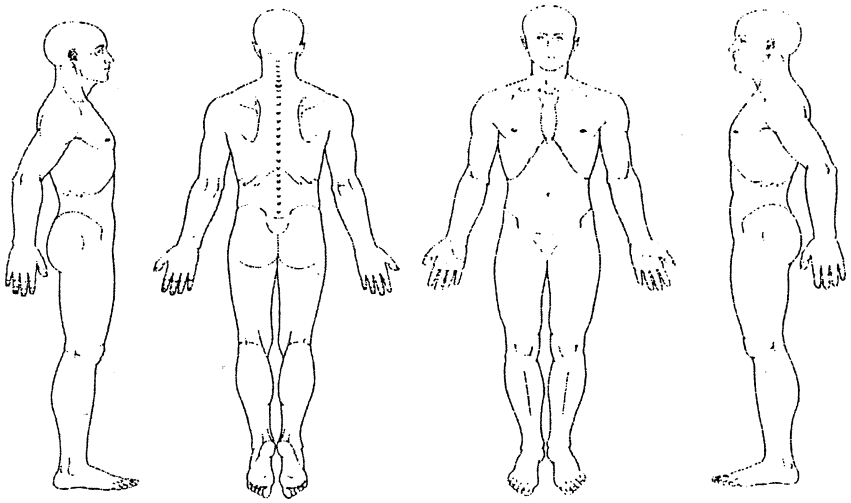
_____

_____

2. 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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

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

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None									Unbearable
a. Worst:	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. Best:	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, interferes 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?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. When and what treatment?

b. 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:_____

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

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

① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

11. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

① Reduce symptoms ③ Explanation of condition/treatment ⑤ How to prevent this from occurring again
② Resume/increase activity ④ Learn how to take care of this on my own ⑥ _____

13. What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have the conditions listed, place a check in the Present column.

Past	*Present*	
❍	❍	Headaches
❍	❍	Neck pain
❍	❍	Upper Back Pain
❍	❍	Mid Back Pain
❍	❍	Low Back Pain
❍	❍	Shoulder Pain
❍	❍	Elbow/Upper Arm Pain
❍	❍	Wrist Pain
❍	❍	Hand Pain
❍	❍	Hip/Upper Leg Pain
❍	❍	Knee/Lower Leg Pain
❍	❍	Ankle/Foot Pain
❍	❍	Jaw Pain
❍	❍	Joint Swelling/Stiffness
❍	❍	Arthritis
❍	❍	Rheumatoid Arthritis
❍	❍	General Fatigue
❍	❍	Muscular Incoordination
❍	❍	Visual Disturbances
❍	❍	Dizziness

Past	*Present*	
❍	❍	High Blood Pressure
❍	❍	Heart Attack
❍	❍	Chest Pains
❍	❍	Stroke
❍	❍	Angina
❍	❍	Kidney Stones
❍	❍	Kidney Disorders
❍	❍	Bladder Infection
❍	❍	Painful Urination
❍	❍	Loss of Bladder Control
❍	❍	Prostate Problems
❍	❍	Abnormal Weight Gain/Loss
❍	❍	Loss of Appetite
❍	❍	Abdominal Pain
❍	❍	Ulcer
❍	❍	Hepatitis
❍	❍	Liver/Gall Bladder Disorder
❍	❍	Cancer
❍	❍	Tumor
❍	❍	Asthma
❍	❍	Chronic Sinusitis

Past	*Present*	
❍	❍	Diabetes
❍	❍	Excessive Thirst
❍	❍	Frequent Urination
❍	❍	Smoking/Use Tobacco Products
❍	❍	Drug/Alcohol Dependence
❍	❍	Allergies
❍	❍	Depression
❍	❍	Systemic Lupus
❍	❍	Epilepsy
❍	❍	Dermatitis/Eczema/Rash
❍	❍	HIV/AIDS

Females Only

❍	❍	Birth Control Pills
❍	❍	Hormonal Replacement
❍	❍	Pregnancy
❍	❍	

Other Health Problems/Issues

❍	❍
❍	❍
❍	❍

Primary Care Physician _____ **Date of Last Medical Physical** _____

Indicate if an immediate family member has had any of the following:

❍ Rheumatoid Arthritis ❍ Heart Problems ❍ Diabetes ❍ Cancer ❍ Lupus ❍ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

_____

List all the surgical procedures you have had and times you have been hospitalized:

_____

_____

Detail any history of trauma to head, neck, or back (automobile accidents, sports injuries, work-related accidents, etc.):

_____

_____

Patient Signature_____ ***Date***_____