

Patient Health Questionnaire

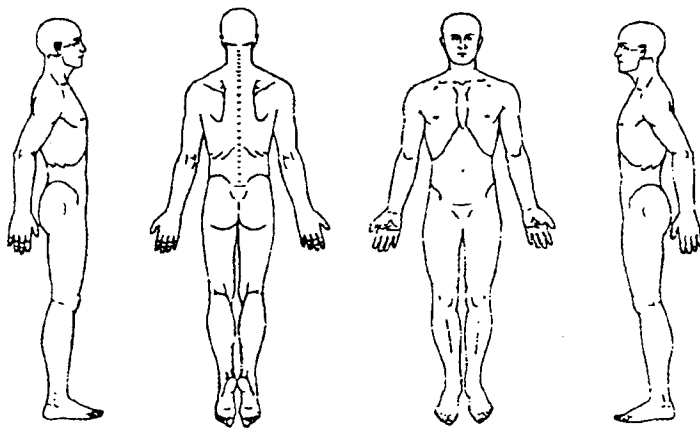
PATIENT NAME _____ DATE _____

Your condition, symptoms are a result of: work sports auto trauma chronic

Describe your condition, symptoms, or the reason for this appointment: _____

_____ Date condition began: _____

Indicate on the pictures below where you have pain or other symptoms **How often do you experience your symptoms?**



- 1-Constantly (76-100% of day)
- 2-Frequently (51-75% of day)
- 3-Occasionally (26-50% of day)
- 4-Intermittently (0-25% of day)

What describes the nature of your symptoms?

- Sharp Shooting
- Dull ache Burning
- Numb Tingling

How are your symptoms changing?

- 1-Getting Better
- 2-Not Changing
- 3-Getting Worse

None Unbearable

What is the intensity of your symptoms at their:

- | | | | | | | | | | | |
|-------|---|---|---|---|---|---|---|---|---|---|
| worst | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| best | ⑩ | ⑨ | ⑧ | ⑦ | ⑥ | ⑤ | ④ | ③ | ② | ① |

Who have you seen for this episode of your symptoms?

- No one Medical Doctor Other
- Other Chiropractor Physical Therapist

When and what treatment? _____

Who is your primary care physician? _____ Phone: _____

Have you had the same or similar symptoms in the past? Yes No

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

- This office Medical Doctor Other
- Other Chiropractor Physical Therapist

What tests have you had for your symptoms?

- X-rays CT Scan MRI Scan Other

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities? Yes No

Describe your restrictions _____

What type of regular exercise do you perform?

- 1-None 2-Light 3-Moderate 4-Strenuous

What is your height and weight?

Height _____

Weight _____ lbs.

Patient Health Questionnaire-Part 2

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 a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/TB
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Rate	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder disorder
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	FEMALES ONLY		
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ear noises)	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
						<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy

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

<input type="checkbox"/> Chronic Back Problems	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lupus
<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other

List all prescription and over-the-counter medications you are taking:

_____	_____	_____
_____	_____	_____

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

_____	_____	_____
_____	_____	_____

Do you smoke? No Yes How much? _____

Drink alcohol? No Yes How much? _____