

Patient Health Questionnaire - New Patient/New Injury Erickson Clinic of Chiropractic
(or 12 months since last visit)

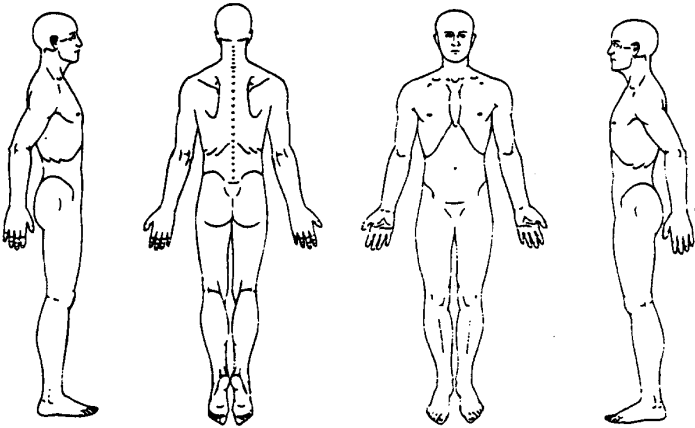
PATIENT NAME _____ DATE _____

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

_____ date condition began: _____

Your condition, symptoms are a result of: _____

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

What is the intensity of your symptoms at their:
(over the past week)

		None										Unbearable									
worst	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	⑪	⑫	⑬	⑭	⑮	⑯	⑰	⑱	⑲	⑲	⑲
best	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	⑪	⑫	⑬	⑭	⑮	⑯	⑰	⑱	⑲	⑲	⑲

Who have you seen for this condition:

- No one Medical Doctor Other
- Other Chiropractor Physical Therapist

When and what treatment: _____

Who is your primary care physician? _____ Phone: _____

Last complete physical exam: _____

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? No one 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"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Stress
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ear noises)	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder disorder
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Sickness			
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones			
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection/UTI			
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain						
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor			
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis						

FEMALES ONLY

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 vitamins/supplements:

Hospitalizations?

List all the surgical procedures you have had :

Do you smoke? Yes No How much? _____

Drink alcohol? Yes No How much? _____