Patient Health Questionnaire

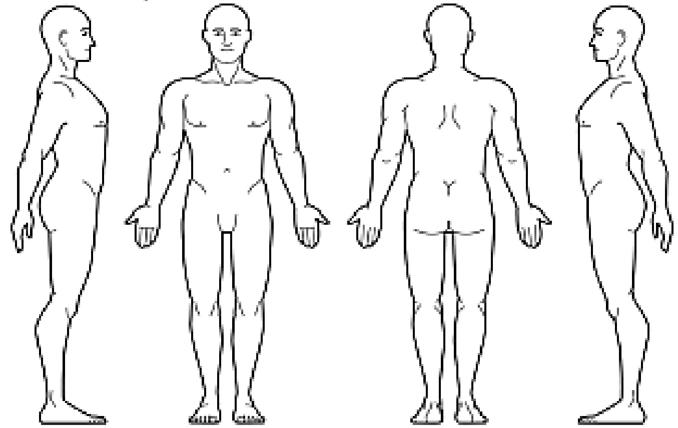
Patient Name: ____ **Date:** _____________________________________

1. Describe your symptoms and how they began:____
____

When did your symptoms start:____________

2. How often do you experience your symptoms?
- □ Constantly (76-100% of the day)
- □ Frequently (51-75% of the day)
- □ Occasionally (26-50% of the day)
- □ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

□ Sharp □ Shooting
□ Dull ache □ Burning
□ Numb □ Tingling

4. How are your symptoms changing?
- □ Getting Better
- □ Not Changing
- □ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	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? □ No One □ Medical Doctor □ Other □ Other Chiropractor □ Physical Therapist

- When and what treatment? ____
- What tests have you had for your symptoms and when were they performed? □ Xrays *date:*______________ □ CT Scan *date:*_____________ □ MRI *date:*______________ □ Other *date:*_____________

10. Have you had 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

11. What is your occupation?

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

□ Reduce symptoms □ Explanation of condition/treatment □ How to prevent this from occurring again
□ Resume/increase activity □ Learn how to take care of this on my own

Patient Health Questionnaire

What type of regular exercise do you perform? □ None □ Light □ Moderate □ Strenuous

What is your height and weight? Height: __________feet __________inches Weight: __________ lbs.

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

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
		Headaches			High Blood Pressure			Diabetes
		Neck Pain			Heart Attack			Excessive Thirst
		Upper Back Pain			Chest Pains			Frequent Urination
		Mid Back Pain			Stroke			
		Low Back Pain			Angina			Smoking/Tobacco Use
								Drug/Alcohol Dependance
		Shoulder Pain			Kidney Stones			
		Elbow/Upper arm Pain			Kidney Disorders			Allergies
		Wrist Pain			Bladder Infection			Depression
		Hand Pain			Painful Urination			Systemic Lupus
					Loss of Bladder Control			Epilepsy
		Hip/Upper Leg Pain			Prostate Problems			Dermatitis/Eczema/Rash
		Knee/Lower Leg Pain						HIV/AIDS
		Ankle/Foot Pain			Abnormal Weight gain/loss			
					Loss of Appetite			**Females Only**
		Jaw Pain			Abdominal Pain			Birth Control Pills
					Ulcer			Hormonal Replacement
		Joint Swelling/Stiffness			Hepatitis			Pregnancy
		Arthritis			Liver/Gall Bladder Disorder			
		Rheumatoid Arthritis						Other Health Issues:
					Cancer			
		General Fatigue			Tumor			
		Muscular Incoordination			Asthma			
		Visual Disturbances			Chronic Sinusitis			
		Dizziness						

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, nutritional/herbal supplements you are taking or provide a copy of a list:

____

____

List all surgical procedures/broken bones/hospitalizations you have had or provide a list to copy:

____

____

Patient Signature ____ Date _______________________

Doctor Signature ____ Date _______________________