Patient Health Questionnaire

Patient Name: _____ ***Date:*** _____

Mailing Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

Home Phone #: _____ ***Other #:*** _____ ***Work Phone #:*** _____

Age: _____ ***Birth Date:*** _____ ***SS#:*** _____ ☐ **Male** ☐ **Female**

Marital Status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Separated** ☐**Widowed** ***Spouse's Name:*** _____

Occupation: _____

Employer: _____ ***How Long:*** _____

Employer's Address: _____

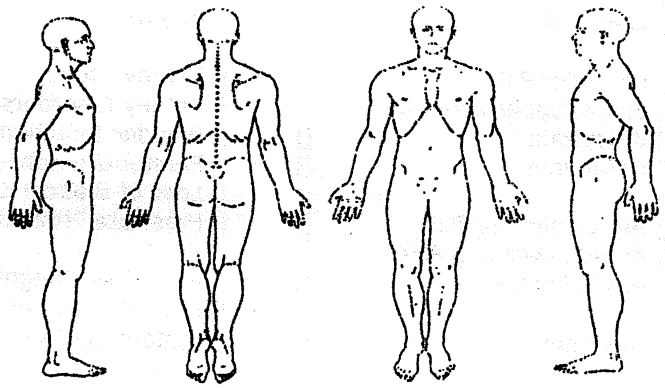
City: _____ ***State:*** _____ ***Zip:*** _____

Referred By: _____

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

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%)

   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:	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*

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

   a. *When and what treatment?* _____

   b. *What tests have you had for your symptoms* ☐ Xrays *date:* _____ ☐ CT Scan *date:* _____ ☐ MRI *date:* _____ ☐ Other *date:* _____

10. ***Have you had similar symptoms in the past?*** ☐ Yes ☐ No

    a. *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

11. What is your occupation?

_____

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

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

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

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/increas activity ☐ Learn how to take care of this on my own ☐ _____

13. What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

14. What is your height and weight? Height _____ Weight _____ lbs.
Feet *Inches*

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*	
☐	☐	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/Use Tobacco
						☐	☐	Drug/Alcohol Dependence
☐	☐	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	☐	☐	Prostrate 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
☐	☐	Joint Swelling/Stiffness	☐	☐	Ulcer	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	
☐	☐	General Fatigue	☐	☐	Cancer	***Other Health Problems/Issues***		
☐	☐	Muscular Uncoordination	☐	☐	Tumor	☐	☐	
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	
☐	☐	Dizziness	☐	☐	Chronic Sinusitis	☐	☐	

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:

_____

_____

Patient Signature _____ ***Date*** _____