## **Patient Health Questionnaire** Date of Birth Patient Name Date 1. When did your symptoms start: \_\_\_\_ Describe your symptoms and how they began: 2. How often do you experience your symptoms? Indicate where you have pain or other symptoms ① Constantly (76-100% of the day) @ Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day) 3. What describes the nature of your symptoms? Sharp Shooting ② Dull ache **®** Burning Numb **©** Tingling 4. How are your symptoms changing? **1** Getting Better Not Changing ③ Getting Worse Unbearable None 5. How bad are your symptoms at their: a. worst: 0: ❽ b. best: -0 0 6. How do your symptoms affect your ability to perform daily activities? No complaints Mild, forgotten Moderate, interferes Severe, no Limiting, prevents Intense, preoccupied with activity with activity full activity with seeking relief activity possible 7. What activities make your symptoms worse: 8. What activities make your symptoms better: Medical Doctor 6 Other 1 No One 9. Who have you seen for your symptoms? Physical Therapist ② Other Chiropractor a. When and what treatment? b. What tests have you had for your symptoms ① Xrays date: \_\_\_\_ ③ CT Scan date: and when were they performed? \_\_\_\_\_ @ Other @ MRI date: \_\_ 10. Have you had similar symptoms in the past? ① Yes @ No a. If you have received treatment in the past for Medical Doctor 6 Other 1 This Office the same or similar symptoms, who did you see? Physical Therapist ② Other Chiropractor. ① Professional/Executive Laborer Retired 11. What is your occupation? White Collar/Secretarial Homemaker ® Other ® FT Student Tradesperson Off work a. If you are not retired, a homemaker, or a ③ Self-employed ① Full-time Other student, what is your current work status? @ Part-time Unemployed 12. What do you hope to get from your visit/treatment (select all that apply): ① Reduce symptoms 3 Explanation of condition/treatment 6 How to prevent this from occurring again

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Learn how to take care of this on my own

Patient Signature

② Resume/increase activity

## Patient Health Questionnaire - page 2

Date of Birth

Patient Name			Date				
What	type of regular exercise do you	perform?	<b>O</b> None	<b>Ø</b> Light		Moderate	Strenuous
What is your height and weight?			Height		!	Weight	ibs.
			Feet	Inches	•	<u> </u>	······································
For e If you	ach of the conditions listed being presently have a condition list	ow, place a ed below, p	check in the Past col	umn if you resent colu	have Imn.	had the cond	lition in the past.
	Present	Past P				Present	
0	O Headaches	0	O High Blood Pressure	8	0	O Diabete	<b>s</b> . ·
0	O Neck Pain	Ο.	O Heart Attack		0	O Excessiv	ve Thirst
0	O Upper Back Pain	0	O Chest Pains		0	O Frequen	t Urination
0	O Mid Back Pain	0	O Stroke				
0	O Low Back Pain	0	O Angina		0		/Use Tobacco Products
_	O Observation Buts		=		0	O Drug/Ald	ohol Dependence
0	O Shoulder Pain	0	O Kidney Stones		_	O 411	
0	O Elbow/Upper Arm Pain	. 0	O Kidney Disorders		0	O Allergies	
0	O Wrist Pain	0	O Bladder Infection		0	O Depress	
0	O Hand Pain	0	O Painful Urination		0	O Systemi	
0	O Hip/Upper Leg Pain	. 0	O Loss of Bladder Con	itrol.	0	O Epilepsy	
Õ	O Knee/Lower Leg Pain	0	O Prostate Problems		0		is/Eczema/Rash
Ô	O Ankle/Foot Pain	Ō	O Abnormal Weight G	ain/l oss	0	O HIV/AID	S
U	O Ankierroot Pain	.0	O Loss of Appetite	411 11 COO	<b></b>	malaa Onke	
0	O Jaw Pain		O Abdominal Pain			nales Only	
~				•	0	O Birth Co	
Ó	O Joint Swelling/Stiffness	0	O Ulcer		0	O Hormona	il Replacement
0	O Arthritis	0	O'Hepatitls		0	O Pregnan	су
0	O Rheumatoid Arthritis	0	O Liver/Gall Bladder D	lsorder	0	0	
0	O Géneral Fatigue	0	O Cancer		Other Health Problems/issues		
ŏ	O Muscular Incoordination	Ō	O Tumor				DIGITIO/1000c0
Ö	O Visual Disturbances				.0	0 .	
Ö	O Dîzziness	0	O Asthma		0	0 .	
0	O Dizzitiess	0	O Chronic Sinusitls		.0	Ο .	
lndi	eta li an lucus elista femilia mand	ar baa baa	l ann a' tha Callandan				
	ate if an-immediate family memb				_		
OK	heumatoid Arthritis O Heart Pr	obiems	O Diabetes O C	Cancer	Ò	Lupus O_	
List a	ll prescription and <mark>over-the-cou</mark>	nter medic	ations, and nutritiona	i/herbal su	pplen	nents you are	taking:
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············			**************************************	<del></del>		<del></del>	
List a	ll the surgical procedures you h	ave had ar	nd times you have bee	n hospitali	ized:		
					-		
Patier	nt Signature			<del></del>			
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