

Patient Health Questionnaire

Patient Name _____

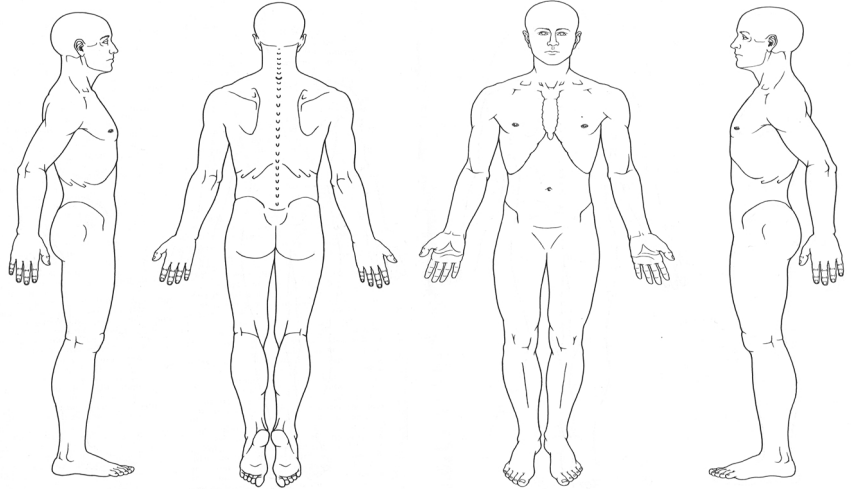
Date _____

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)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

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

5. How bad are your symptoms at their:

- | | | | | | | | | | | | |
|------------------|------|---|---|---|---|---|---|---|---|---|------------|
| | None | | | | | | | | | | |
| a. worst: | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ | Unbearable |
| b. best: | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ | |

6. How do your symptoms affect your ability to perform daily activities?

- | | | | | | | | | | |
|---------------|-------------------------------|------------------------------------|----------------------------------|--|------------------------------|---|---|---|---|
| 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?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays
- ② MRI
- ③ CT Scan date: _____
- ④ Other date: _____

10. Have you had any injuries or surgeries since your last visit?

- ① Yes
- ② No

11. Have you had similar symptoms in the past?

- ① Yes
- ② No

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

- ① This Office
- ② Other Chiropractor
- ③ Other

12. What is your occupation? _____

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

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

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

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again

Patient Signature _____

Date _____

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Patient Name _____ **Date** _____

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.
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
<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Neck Pain	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	Excessive Thirst
<input type="radio"/>	<input type="radio"/>	Upper Back Pain	<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	Frequent Urination
<input type="radio"/>	<input type="radio"/>	Mid Back Pain	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Osteoporosis
<input type="radio"/>	<input type="radio"/>	Low Back Pain	<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Aneurysm (abdominal or other)
<input type="radio"/>	<input type="radio"/>	Shoulder Pain	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Bleeding disorder
<input type="radio"/>	<input type="radio"/>	Elbow/Upper Arm Pain	<input type="radio"/>	<input type="radio"/>	Kidney Disorders	<input type="radio"/>	<input type="radio"/>	Inflammatory arthritis
<input type="radio"/>	<input type="radio"/>	Wrist Pain	<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Smoking/Use Tobacco Products
<input type="radio"/>	<input type="radio"/>	Hand Pain	<input type="radio"/>	<input type="radio"/>	Painful Urination	<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Dependence
<input type="radio"/>	<input type="radio"/>	Hip/Upper Leg Pain	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control	<input type="radio"/>	<input type="radio"/>	Allergies
<input type="radio"/>	<input type="radio"/>	Knee/Lower Leg Pain	<input type="radio"/>	<input type="radio"/>	Prostate Problems	<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Ankle/Foot Pain	<input type="radio"/>	<input type="radio"/>	Abnormal Weight Gain/Loss	<input type="radio"/>	<input type="radio"/>	Systemic Lupus
<input type="radio"/>	<input type="radio"/>	Jaw Pain	<input type="radio"/>	<input type="radio"/>	Loss of Appetite	<input type="radio"/>	<input type="radio"/>	Epilepsy
<input type="radio"/>	<input type="radio"/>	Joint Swelling/Stiffness	<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema/Rash
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Ulcer	<input type="radio"/>		
<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	Hepatitis			
<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder			
<input type="radio"/>	<input type="radio"/>	Muscular Incoordination	<input type="radio"/>	<input type="radio"/>	Cancer			
<input type="radio"/>	<input type="radio"/>	Visual Disturbances	<input type="radio"/>	<input type="radio"/>	Tumor			
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Asthma			
			<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis			

Females Only

AIDS

Birth Control Pills

Hormonal Replacement

Pregnancy

Other Health Problems/Issues

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** _____

Doctor's Additional Comments

Doctors Signature _____ **Date** _____

Have you had any changes in your Contact Information? (address, phone number, email address)

Yes No

If yes, please indicate change:

Have you had any change of insurance or any updates within your current policy?

Yes No

If yes, please inform the front desk staff

I understand the intake information and have accurately completed it to the best of my knowledge. It is my responsibility to inform this office of any changes to the information I have provided. Entering/typing name in the signature field above constitutes signing the document, confirming the signer has read, understands, and agrees to the terms and conditions stated.

Patient Signature _____ Date: _____