Patient Health Questionnaire

Patient Name ______________________________ ***Date*** ____________________

1. Describe your current symptoms (Begin with what bothers you the most) ______________________________

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2. When did your symptoms begin ? ______________________________

3. What activities make your symptoms worse?

(1) Ice (3) Rest (5) Sitting (7) Medication
(2) Heat (4) Activity (6) Standing (8) Other

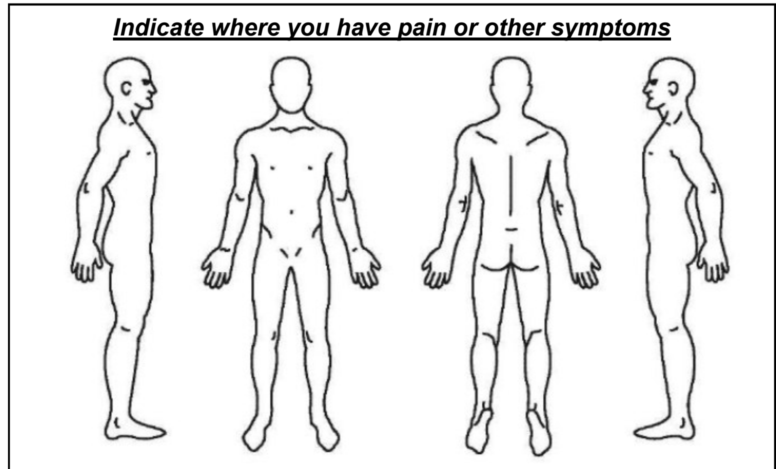
4. What activities make your symptoms better?

(1) Ice (3) Rest (5) Sitting (7) Medication
(2) Heat (4) Activity (6) Standing (8) Other

5. What describes the nature of your symptoms?

(1) Sharp (4) Shooting
(2) Dull Ache (5) Burning
(3) Numb (6) Tingling

6. Draw the location of your symptoms on Diagram →



NRP
RSO
RTB
RLAS RRAS
RLAE RRAE
RLAH RRAH
RBB
RLLB RRLB
RLLK RRLK
RLLA RRLA
REF

7. What describes the severity of your symptoms?

None 1 2 3 4 5 6 7 8 9 10 Severe

8. How are your symptoms changing ?

(1) Getting Better
(2) Not Changing
(3) Getting Worse

9. Who else have you seen for your current symptoms?

(1) No One (3) Medical Doctor (5) This Office
(2) Other Chiropractor (4) Physical Therapist (6) Other: ____________

10. b. What tests have you had for your symptoms?

(0) None (1) X-rays date :__________ (3) CT Scan date: ____________
(2) MRI date: ____________ (4) Other date:______________

11. What other forms of care have you tried for your current complaint?

(1) Nothing (3) Muscle Relaxer (5) Advil/Tylenol/Aleve, etc (7) Injections
(2) Pain Medication (4) Ice/Heat (6) Physical Therapy (8) Other: ____________

12. What do you feel caused your symptoms? (1) Fall (3) Lifting (5) Work
(2) Car Accident (4) Don't Know (6) Other: ____________

13. What activities are effected by your symptoms?

(1) Work/School (3) Sleeping (5) Driving/Riding in Car (7) Golf (9) Exercising
(2) Walking (4) Running (6) House Work (8) Yard Work (10) Other______________

14. Have you had similar symptoms in the past? (Y) Yes When? __________________ (N) No

15. If yes, whom did you see?

(1) No One (3) Medical Doctor (5) This Office
(2) Other Chiropractor (4) Physical Therapist (6) Other: ____________

16. What is your occupation?

(1) Professional/Executive (4) Laborer (7) Retired
(2) White Collar/Secretarial (5) Homemaker (8) Other: __________
(3) Tradesperson (6) F/T Student

17. What type of regular exercise do you perform? (1) None (2) Light (3) Moderate (4) Strenuous

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 have the conditions listed, place a check in the* PRESENT *column.

Many of the following conditions respond to chiropractic and acupuncture

#	18. PAST	19. PRESENT	Condition	#	PAST	PRESENT	Condition	#	PAST	PRESENT	Condition
1	( )	( )	Headaches	21	( )	( )	High Blood Pressure	43	( )	( )	Diabetes
2	( )	( )	Neck Pain	22	( )	( )	Heart Attack	44	( )	( )	Excessive Thirst/Urination
3	( )	( )	Upper Back Pain	23	( )	( )	Chest Pains	45	( )	( )	Thyroid Disorder
4	( )	( )	Mid Back Pain	24	( )	( )	Stroke	46	( )	( )	Smoking/Tobacco Use
5	( )	( )	Low Back Pain	25	( )	( )	Angina	47	( )	( )	Drug/Alcohol Dependence
6	( )	( )	Shoulder Pain	26	( )	( )	Kidney Stones	48	( )	( )	Food Allergies
7	( )	( )	Elbow/Upper Arm Pain	27	( )	( )	Kidney Disorder	49	( )	( )	Depression
8	( )	( )	Wrist Pain	28	( )	( )	Bladder Infection	50	( )	( )	Frequent Illness
9	( )	( )	Hand Pain	29	( )	( )	Painful Urination	51	( )	( )	Epilepsy
				30	( )	( )	Loss of Bladder Control	52	( )	( )	Dermatitis/Eczema/Rash
10	( )	( )	Hip/Upper Leg Pain	31	( )	( )	Prostate Problems	53	( )	( )	HIV/AIDS
11	( )	( )	Knee/Lower Leg Pain								
12	( )	( )	Ankle/Foot Pain	32	( )	( )	Abnormal Weight Gain/Loss		***Females Only***		
				33	( )	( )	Loss of Appetite	54	( )	( )	Hot Flashes
13	( )	( )	Jaw Pain/TMJ	34	( )	( )	Abdominal Pain	55	( )	( )	Hormone Replacement
				35	( )	( )	Ulcer	56	( )	( )	Birth Control Pills
14	( )	( )	Joint Swelling/Stiffness	36	( )	( )	Hepatitis	57	( )	( )	Painful Periods/Cramps
15	( )	( )	Arthritis	37	( )	( )	Liver/Gall Bladder Disorder	58	YES	NO	Are You Pregnant?
16	( )	( )	Rheumatoid Arthritis						Estimated Due Date ________________		
				38	( )	( )	Cancer				
17	( )	( )	General Fatigue	39	( )	( )	Tumor		***Other Health Problems***		
18	( )	( )	Ringing in Ears	40	( )	( )	Asthma	59	( )	( )	____________________
19	( )	( )	Visual Disturbances	41	( )	( )	Chronic Sinusitis	60	( )	( )	____________________
20	( )	( )	Dizziness	42	( )	( )	Seasonal Allergies	61	( )	( )	____________________

20. Primary Care Physician__________________________________ **20b. Date of Last Medical Physical**___________________

21.Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: ____________

22. List all prescription and over-the-counter medications, nutritional/herbal supplements you are taking:

____

____

23. List all the surgical procedures you have had and times you have been hospitalized:

____

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24. Detail any history of trauma to head, neck, or back (automobile accidents, sports injuries, work-related accidents, etc):

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Patient Signature____ ***Date***________________________