Patient Health Questionnaire – Page 1

Patient Name____ **Date** _______________________

1. Describe your symptoms: ____

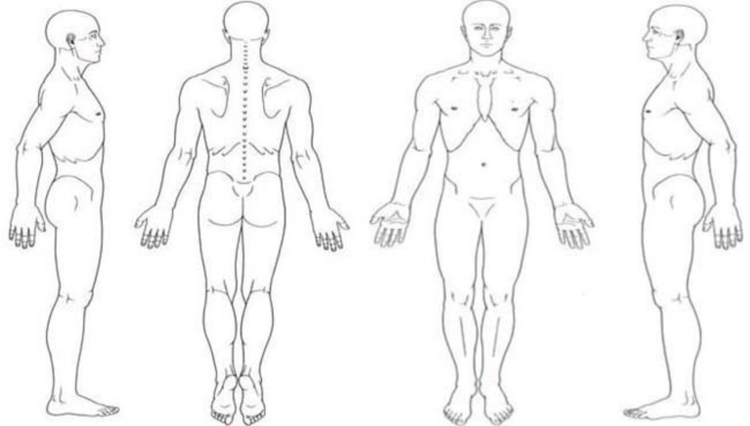
____

a. When did your symptoms start? ____

b. How did your symptoms begin? ____

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

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
1) Sharp 4) Shooting
2) Dull Ache 5) Burning
3) Numb 6) Tingling

4. How are your symptoms changing?
1) Getting Better
2) Not Changing
3) Getting Worse

5. Average pain intensity

	None										Unbearable
a) Last 24 hours:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
b) Past Week:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

6. How much has pain interfered with your normal work (including both work outside the home & housework)?
1) Not at all 2) A little bit 3) Moderately 4) Quite a bit 5) Extremely

7. In general, would you say your overall health <u>right now</u> is…
1) Excellent 2) Very Good 3) Good 4) Fair 5) Poor

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8. Who have you seen for your symptoms? 1) No one 2) Chiropractor 3) Medical Doctor 4) Physical Therapist 5) Other _______________________

a. What treatment did you receive and when? ____

b. What tests have you had for your symptoms and when were they performed?
1) X-rays date: ________ 2) MRI date: ____________
3) CT Scan date: ________ 4) Other date: ____________

9. 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?
1) This office 2)Another Chiropractor 3) Medical Doctor
4) Physical Therapist 5) Other _____________________

10. What is your occupation?

____

1) Professional/Executive 2) White Collar/Secretarial
3) Tradesperson 4) Laborer 5) Homemaker
6) FT Student 7) Retired 8) Other

a. If you are <u>not</u> retired, a homemaker, or a
1) Full-Time 2) Part-Time 3) Self Employed
4) Unemployed 5) Off Work 6) Other

Patient Signature ____ **Date** _______________________

Patient Health Questionnaire – page 2

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 [ ][ ][ ] (Feet, Inches) Weight [ ][ ][ ] lbs.

Fore 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	○	○	Smoking/Tobacco Products
○	○	Low Back Pain	○	○	Angina	○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones	○	○	Allergies
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Depression
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Systemic Lupus
○	○	Hand Pain	○	○	Painful Urination	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Loss of Bladder Control	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain	○	○	Prostate Problems	○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			**Females Only**
○	○	Jaw Pain	○	○	Loss of Appetite	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Abdominal Pain	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Ulcer	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Hepatitis			**Other Health Problems/Issues**
○	○	General Fatigue	○	○	Liver/Gall Bladder Disorder			____________
○	○	Muscular In coordination	○	○	Cancer			____________
○	○	Visual Disturbances	○	○	Tumor			____________
○	○	Dizziness	○	○	Asthma			____________
			○	○	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 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

____

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Doctor's Signature________________________________ **Date**____________