Patient Health Questionnaire

Name: _____ Date: _____

1. Please describe your complaint:

_____

_____

_____

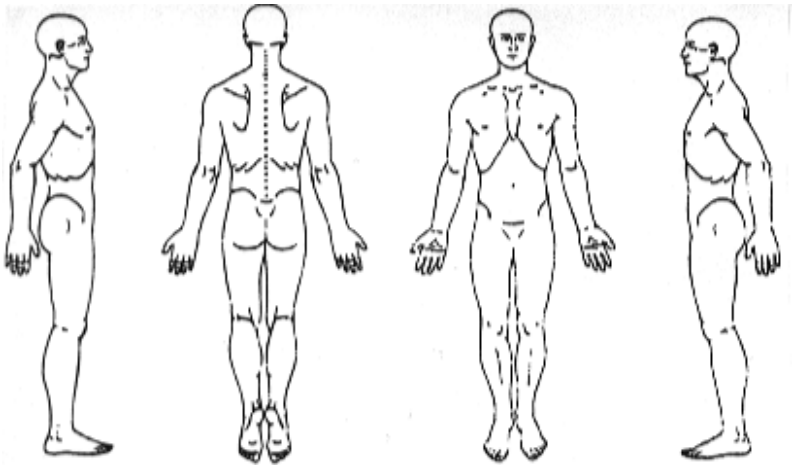
a. Description:

- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency

- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25% or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



c. Indicate intensity of your pain at its LOWEST and HIGHEST level:

No pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

d. Your symptoms are: ☐ decreasing ☐ not changing ☐ increasing

e. Symptoms are worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ Increase during the day ☐ Same all day

f. Your symptoms: ☐ are localized in one area ☐ travel down the arms or legs

2. When did your problems begin? SPECIFIC DATE IF POSSIBLE _____

Describe how your problem began: _____

_____

_____

3. Have you been treated **for this episode**? ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Massage Therapist ☐Physical Therapist ☐ Osteopath ☐ Other
When and what did treatment consist of? Date: _____ Description: _____

_____

4. **In the past** have you been treated for the same or similar problem? ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Massage Therapist ☐Physical Therapist ☐ Osteopath ☐ Other _____
When and what did treatment consist of? _____

_____

5. Have you ever had an injury to the area of complaint described above? ☐ Yes ☐ No Explain: _____

_____

6. What makes your problem **better**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

7. What makes your problem **worse**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

8. What self-treatment have you tried? ☐ Ice ☐ Heat ☐ Pain Medication ☐ Muscle Relaxants ☐ Other _____

9. General Physical Activity: ☐ No exercise program ☐ Light exercise program ☐ Moderate exercise program ☐ Strenuous exercise program

10. Have you ever been involved in a motor vehicle accident? ☐ Yes ☐ No Date(s): _____

11. How would you rate your stress level? ☐ Little or no stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

Patient's Signature: _____ Date: _____

Please Turn Page Over

If you have ever had a listed condition in the past, please check it in the Past Column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

Past	Present		Past	Present	
☐	☐	Neck Pain (723.1)	☐	☐	Aortic Aneurysm (441.5)
☐	☐	Low Back Pain (847.2)	☐	☐	High Blood Pressure (401.9)
☐	☐	Shoulder pain (719.41)	☐	☐	Angina (413.9)
☐	☐	Pain in Upper Arm or Elbow (719.42)	☐	☐	Heart Attack (410.9)
☐	☐	Hand Pain (719.44)	☐	☐	Stroke (436)
☐	☐	Wrist Pain (719.43)	☐	☐	Asthma (493.9)
☐	☐	Upper Back Pain (724.2)	☐	☐	Cancer (199.1)
☐	☐	Pain in Upper Leg or Hip (719.45)	☐	☐	Tumor (229.9)
☐	☐	Pain in Ankle or Foot (719.47)	☐	☐	Prostate Problems (601.9)
☐	☐	Jaw Pain (526.9)	☐	☐	Blood Disorder (790.6)
☐	☐	Swelling/Stiffness of Joints(s)	☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Fainting (780.2)	☐	☐	Arthritis (716.9)
☐	☐	Visual Disturbances (368.9)	☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Convulsions (780.3)	☐	☐	Diabetes (250.0)
☐	☐	Dizziness (780.4)	☐	☐	Epilepsy (349.5)
☐	☐	Headache (784.0)	☐	☐	Ulcer (556.9)
☐	☐	Muscular Incoordination (781.3)	☐	☐	Liver (573.9)/Gallbladder (575.9) problems
☐	☐	Tinnitus (Ear Noises) (388.30)	☐	☐	Kidney Stones (592.0)
☐	☐	Rapid Heart Beat (785.0)	☐	☐	Hepatitis (573.3)
☐	☐	Chest Pains (786.50)	☐	☐	Bladder Infection (595.9)
☐	☐	Loss of Appetite (783.0)	☐	☐	Kidney Disorders
☐	☐	Anorexia (307.1)	☐	☐	Colitis (558.9)
☐	☐	Abnormal Weight:	☐	☐	Irritable Colon (564.1)
		☐ Gain (783.1)☐ Loss (783.2)	☐	☐	HIV/Aids (042)
☐	☐	Excessive Thirst (783.5)	☐	☐	Systemic Lupus
☐	☐	Chronic Cough (786.2)	☐	☐	Osteoporosis
☐	☐	Chronic Sinusitis (473.9)	☐	☐	Thyroid ☐ Hypo ☐ Hyper
☐	☐	General Fatigue (780.7)	☐	☐	Other_____
☐	☐	Irregular Menstrual Flow (626.4)			
☐	☐	Profuse Menstrual Flow (626.7)			
☐	☐	Breast Soreness/Lumps (611.72)			
☐	☐	Endometriosis (617.9)			
☐	☐	PMS (625.4)			
☐	☐	Loss of Bladder Control (788.30)			
☐	☐	Painful Urination (788.1)			
☐	☐	Frequent Urination (788.41)			
☐	☐	Abdominal Pain (789.0)			
☐	☐	Constipation/irregular bowel habits (564.0)			
☐	☐	Difficulty in Swallowing (787.2)			
☐	☐	Dermatitis/Eczema/Rash (692.9)			
☐	☐	Depression (311)			

If a family member has had any of the following please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart problems	☐ Systemic Lupus
☐ Lung Problems	☐ Osteoporosis
☐ High Blood Pressure	☐ Thyroid Problems
☐ Stroke	☐ Other Conditions

_____

_____

_____

Please check any of the following that apply to you.

Past	Present		Past	Present	
☐	☐	Pregnancy (V22.2)	☐	☐	Tobacco (305.1)
☐	☐	Birth Control Pills	☐	☐	Alcohol (305.0)
☐	☐	Hormonal/Estrogen replacement	☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Medications (list if not listed elsewhere)	☐	☐	Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day _____
		_____			_____
		_____			
☐	☐	Hospitalizations/Surgical Procedures (list if not elsewhere described _____			
		_____			

Present: Weight:_____pounds Height:____feet___inches

Patient's Signature: _____ Date: _____

Doctor's Additional Comments/ General Health Concerns: