

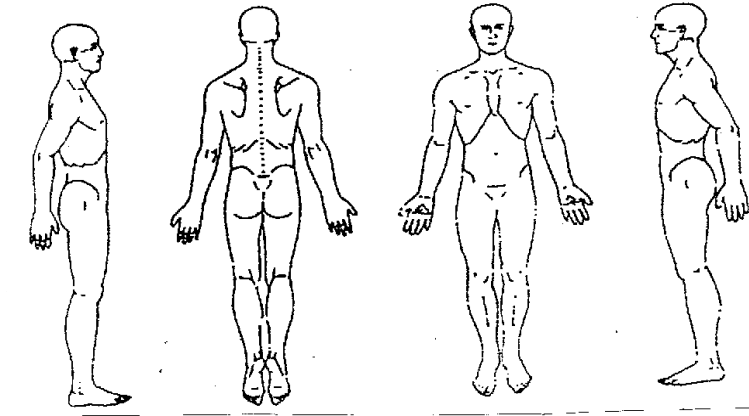
Patient Health Questionnaire
(Please Print)

Patient Name _____ Date _____

When did your symptoms start? _____ Describe your symptoms and how they began _____

Indicate on the pictures below where you have pain or other symptoms

How often do you experience your symptoms?



- 1-Constantly (76-100% of day)
- 2-Frequently (51-75% of day)
- 3-Occasionally (26-50% of day)
- 4-Intermittently (0-25% of day)

What describes the nature of your symptoms?

- Sharp Shooting
- Shooting Dull ache Burning
- Dull Ache Burning
- Numb Tingling

How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

What is the intensity of your symptoms as their:

	None										Unbearable
Worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	5	6	7	8	9	
Best	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Who have you seen for this episode of your symptoms?

- No One Medical Doctor Other
- Other Chiropractor Physical Therapist

When and what treatment? _____

Have you had the same or similar symptoms in the past? Yes No

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

- This Office Medical Doctor Other
- Other Chiropractor Physical Therapist

What tests have you had for your symptoms? Xrays CT Scan MRI Scan Other

What is your occupation?

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

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

- 1-Full-time 4-Unemployed
- 2-Part-time 5-Employed, off work due to restrictions
- Self-employed

As a result of your symptoms are you restricted in your ability to perform work and/or daily activities? Yes No

Describe your restrictions _____

What type of regular exercise do you perform? 1-None 2-Light 3-Moderate 4-Strenuous

What is your height and weight? Height _____ Weight _____

(Cont on back)

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="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat			
			<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	Elbow, Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain						
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression
			<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
			<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain						
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight gain/loss			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
			<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue						
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing			
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation			
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn Indigestion			
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Colitis			
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ear noises)	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			

Females Only

<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy

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

<input type="checkbox"/> Chronic Back Problems	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lupus
<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other

Do you have a permanent disability rating? Yes No Rating % _____ Date Rating Received _____

Describe your disability _____

List all prescription and over-the-counter medications you are taking

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

List all accident and/or injuries: (Especially those related to your present problems)

Patient Signature _____ Date _____

Doctors Additional Comments:

Doctor Signature _____ Date _____