

# Patient Health Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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

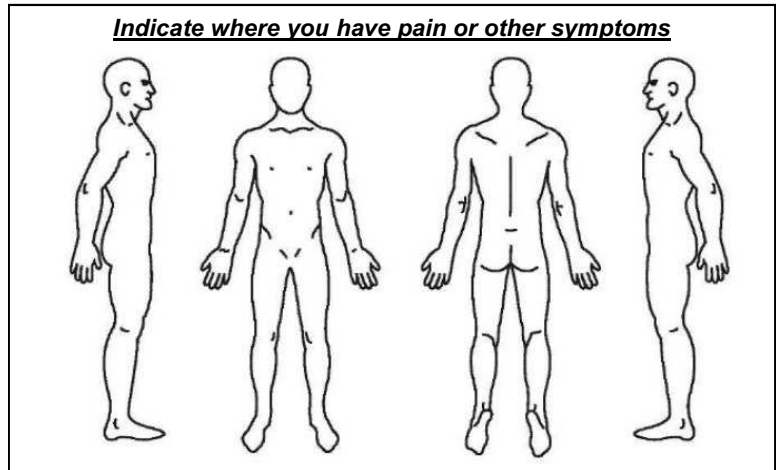
2. When did your symptoms begin? \_\_\_\_\_

3. What activities make your symptoms worse? (1) Ice (2) Heat (3) Rest (4) Activity (5) Sitting (6) Standing (7) Medication (8) Other

4. What activities make your symptoms better? (1) Ice (2) Heat (3) Rest (4) Activity (5) Sitting (6) Standing (7) Medication (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

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 (2) Other Chiropractor (3) Medical Doctor (4) Physical Therapist (5) This Office (6) Other: \_\_\_\_\_

Provider's name: \_\_\_\_\_

10. What tests have you had for your symptoms?

- (0) None (1) X-rays date: \_\_\_\_\_ (2) MRI date: \_\_\_\_\_ (3) CT Scan date: \_\_\_\_\_ (4) Other date: \_\_\_\_\_

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

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

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

13. What activities are affected by your symptoms?

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

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

15. If yes, whom did you see? (1) No One (2) Other Chiropractor (3) Medical Doctor (4) Physical Therapist (5) This Office (6) Other: \_\_\_\_\_

16. What is your occupation? (1) Professional/Executive (2) White Collar/Secretarial (3) Tradesperson (4) Laborer (5) Homemaker (6) F/T Student (7) Retired (8) Other: \_\_\_\_\_

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.		19.									
PAST	PRESENT			PAST	PRESENT	PAST	PRESENT				
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	<b>Females Only</b>			
				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	<b>Other Health Problems</b>			
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:

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT INTRODUCTION CARD

No.: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Dr. Mr. Mrs. Miss Ms.): \_\_\_\_\_ Phone (Home): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Married: \_\_\_ Single: \_\_\_ Other: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Phone (Office): \_\_\_\_\_ Email: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Previous Chiropractic Care? \_\_\_ Yes \_\_\_ No Doctor's Name: \_\_\_\_\_

Name of your Insurance Company: \_\_\_\_\_

Major Complaint: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Who (or what source) referred you? \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*