Patient Health Questionaire - Page 1

Patient Name _____ *Date* _____

1. *When did your symptoms start:* _____
Describe your symptoms and how they began: _____

_____

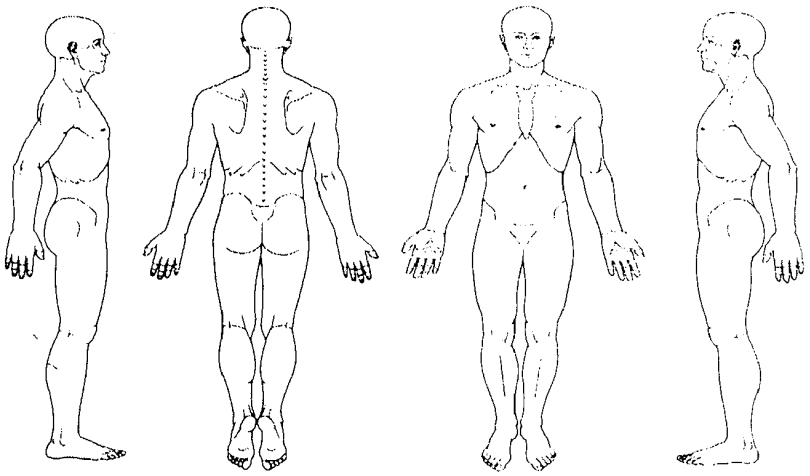
_____

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

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

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

Indicate where you have pain or other symptoms



5. *How bad are your symptoms at their:*

		None									Unbearable
a.	*Worst:*	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) (10)
b.	*Best*	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) (10)

6. *How do your symptoms affect your ability* to *perform daily activities?*

(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
No complaints	*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*			*Severe, no activity possible*

7. *What activities make your symptoms worse:* _____

8. *What activities make your symptoms better:* _____

Who have you seen for your symptoms?
(1) No One
(2) Other Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

a. *When and what treatment?* _____

b. What tests have you had for your symptoms and when were they performed?
(1) Xrays *date:*_____
(2) MRI *date:*_____
(3) CT Scan *date:* _____
(4) Other *date:* _____

10. *Have you had similar symptoms in the past?* (1) Yes (2) No

a. *If you have received treatment in the past for the same or similar symptoms, who did you see?*
(1) This Office
(2) Other Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

11. *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 not retired,* a *homemaker, or* a *student, what is your current work status?*
(1) Full-time
(2) Part-time
(3) Self-employed
(4) Unemployed
(5) Off work
(6) Other

12. *What do you hope to get from your visit/treatment (select all that apply)*
(1) Reduce Symptoms
(2) Resume/increase activity
(3) Explanation of condition/treatment
(4) Learn how to take care of this on my own
(5) How to prevent this from occurring again (6)

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:_____ Weight:_____

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*		
O	O	Headaches		O	O	High Blood Pressure		O	O	Diabetes	
O	O	Neck Pain		O	O	Heart Attack		O	O	Excessive Thirst	
O	O	Upper Back Pain		O	O	Chest Pains		O	O	Frequent Urination	
O	O	Mid Back Pain		O	O	Stroke					
O	O	Low Back Pain		O	O	Angina		O	O	Smoking/Use Tobacco Products	
								O	O	Drug/Alcohol Dependence	
O	O	Shoulder Pain		O	O	Kidney Stones					
O	O	Elbow/Upper Arm Pain		O	O	Kidney Disorders		O	O	Allergies	
O	O	Wrist Pain		O	O	Bladder Infection		O	O	Depression	
O	O	Hand Pain		O	O	Painful Urination		O	O	Systemic Lupus	
				O	O	Loss of Bladder Control		O	O	Epilepsy	
O	O	Hip/Upper Leg Pain,		O	O	Prostate Problems		O	O	Dermatitis/Eczema/Rash	
O	O	Knee/Lower Leg Pain						O	O	HIV/AIDS	
O	O	Ankle/Foot Pain		O	O	Abnormal Weight Gain/Loss					
								Females Only			
								O	O	Birth Control Pills	
O	O	Joint Swelling/Stiffness		O	O	Ulcer		O	O	Hormonal Replacement	
O	O	Arthritis		O	O	Hepatitis		O	O	Pregnancy	
O	O	Rheumatoid Arthritis		O	O	Liver/Gall Bladder Disorder		O	O		
O	O	General Fatigue		O	O	Cancer		*Other Health Problems/Issues*			
O	O	Muscular Incoordination		O	O	Tumor		O	O		
O	O	Visual Disturbances		O	O	Asthma		O	O		
O	O	Dizziness		O	O	Chronic Sinusitis		O	O		

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

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus

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

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

Patient Signature _____ *Date* _____

Doctors Additional Comments:

Doctors Signature _____ *Date* _____