

Patient Health Questionnaire

Name: _____ Date: _____

1. Please describe your complaint:

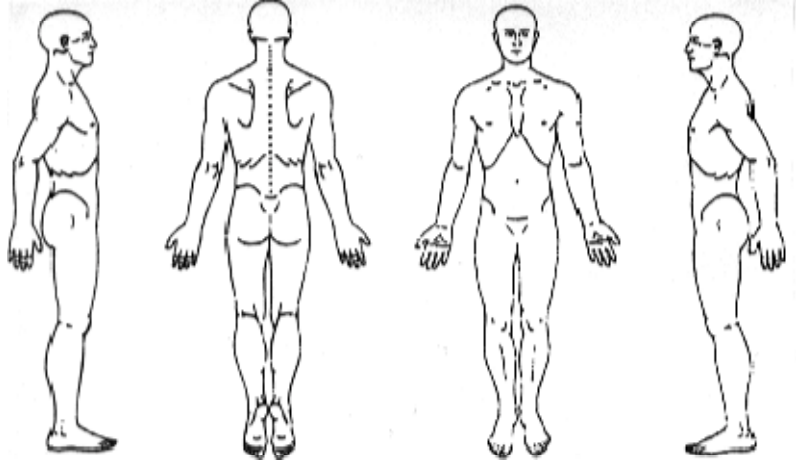
a. Description:

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

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

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Other Conditions

Please check any of the following that apply to you.

<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy (V22.2)	Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco (305.1)
<input type="checkbox"/>	<input type="checkbox"/>	Hormonal/Estrogen replacement	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol (305.0)
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere)	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence (303.9)
		_____	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft Drinks:
		_____			cups/cans per day _____
<input type="checkbox"/>	<input type="checkbox"/>	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: