Serenity Health & Wellness

Patient Health Questionnaire

Name: ____ **Date:** ______________________

1. Please describe your complaint:

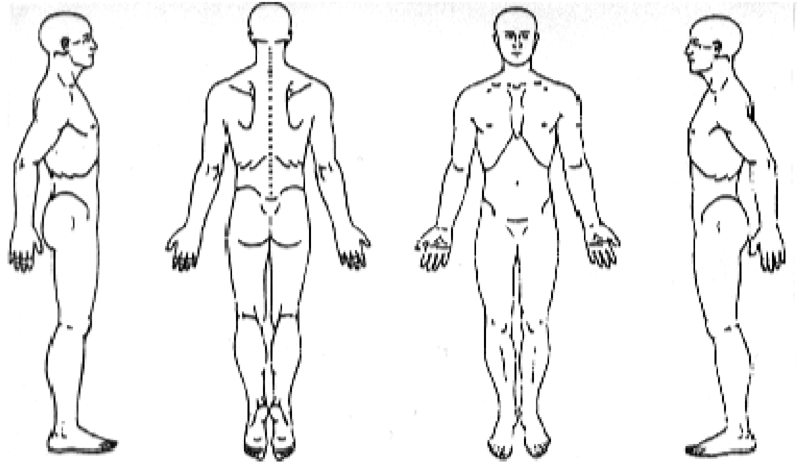
a. Description:

- ☐ 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:

____

2. 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:______________________________

____

3. 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? ____

____

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

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

6. What makes your problem **worse**? ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other______________

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

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

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

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

Patient's Signature: ____ **Date:** ______________________

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	
☐	☐	Neck Pain (723.1)
☐	☐	Low Back Pain (847.2)
☐	☐	Shoulder pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joints(s)
☐	☐	Fainting (780.2)
☐	☐	Visual Disturbances (368.9)
☐	☐	Convulsions (780.3)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear Noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia (307.1)
☐	☐	Abnormal Weight: ☐ Gain (783.1) ☐ Loss (783.2)
☐	☐	Excessive Thirst (783.5)
☐	☐	Chronic Cough (786.2)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	General Fatigue (780.7)
☐	☐	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)

Past	Present	
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Angina (413.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Tumor (229.9)
☐	☐	Prostate Problems (601.9)
☐	☐	Blood Disorder (790.6)
☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Diabetes (250.0)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (556.9)
☐	☐	Liver (573.9)/Gallbladder (575.9) problems
☐	☐	Kidney Stones (592.0)
☐	☐	Hepatitis (573.3)
☐	☐	Bladder Infection (595.9)
☐	☐	Kidney Disorders
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/Aids (042)
☐	☐	Systemic Lupus
☐	☐	Osteoporosis
☐	☐	Thyroid ☐ Hypo ☐ Hyper
☐	☐	Other______________________________

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	
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen replacement
☐	☐	Medications (list if not listed elsewhere ______________________________
☐	☐	Hospitalizations/Surgical Procedures (list if not elsewhere described ______________________________

Past	Present	
☐	☐	Tobacco (305.1)
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Alcohol (305.0)
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day ______________________________

Present: Weight:_______pounds   Height:____feet___inches

Patient's Signature: ____ **Date:** ______________________