Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name ______________________ **Date** ______________________

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

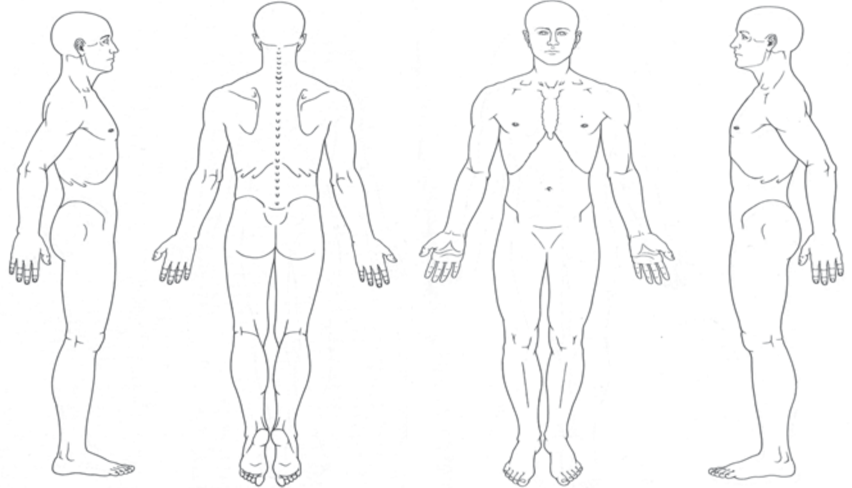
____

Primary Care Provider/Referrer: ______________________

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

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

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

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: ______________________

9. Who have you seen for your symptoms?

☐ No One ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

a. When and what treatment? ______________________

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* __________ ☐ CT Scan *date:* __________

☐ MRI *date:* __________ ☐ Other *date:* __________

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

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

☐ This Office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other

11. What is your occupation?

☐ Professional/Executive ☐ White Collar/Secretarial ☐ Tradesperson ☐ Laborer ☐ Homemaker ☐ FT Student ☐ Retired ☐ Other

____

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

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work ☐ Other

12. What do you hope to get from your visit/treatment *(select all that apply)*:

- ☐ Reduce symptoms
- ☐ Resume/increase activity
- ☐ Explanation of condition/treatment
- ☐ Learn how to take care of this on my own
- ☐ How to prevent this from occurring again
- ☐

Patient Signature ______________________ **Date** ______________________

Patient Health Questionnaire - page 2

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ChiroCare Use Only rev 1/20/99

Patient Name ______________________ ***Date*** ____________

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height [ ] [ ] [ ] (Feet, Inches) Weight [ ] [ ] [ ] lbs.

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	Condition
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	Condition
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	Condition
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS
		Females Only
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	
		Other Health Problems/Issues
☐	☐	
☐	☐	
☐	☐	

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

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ 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*** ____________

Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ ***Date*** ____________

Whole Family
CHIROPRACTORS

Name:____Date:_______________

Activities of Daily Living Assessment (1/2)

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1-5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty:
1= “I can do it without any difficulty”
2= “I can do it without much difficulty, despite some pain”
3= “I manage to do it by myself, despite marked pain”
4= “I manage to do it, despite the pain, but only if I have help”
5= “I cannot do it at all, because of the pain”
NOTE: Only fill in areas that are affected.

Difficulties with Self Care and Personal Hygiene Activities:

__ Bathing __ drying hair __ brushing teeth __ putting on shoes __ taking out trash__ showering __ combing hair

__ making bed __ tying shoes __eating __ doing laundry__ washing hair __ washing face __putting on pants __ dishes

__ going to bathroom

Difficulties with Physical Activities:

__ bending forward __ bending back __twisting left __ twisting right__ bending left __ leaning left __ bending right

__ leaning right__ kneeling __ sitting __ stooping __ reaching __ reclining __ squatting

__ standing for long periods (30 minutes) __ walking for long periods (>30 minutes)

Difficulties with Functional Activities:

__ carrying small objects __ lifting weights off floor __ pushing things while seated__ exercising upper body

__ carrying large objects __lifting objects off table __pushing things while standing __ exercising lower body

__ carrying computer case__ climbing stairs __ pulling things while seated __ exercising arms

__ carrying large purse __ climbing inclines __pulling things while standing

Difficulties with Social and Recreational Activities:

__ bowling __ jogging __ swimming __ working out __ competitive sports __ socializing

__ golfing __ dancing __skiing __ roller skating __ hobbies __ dining out

Difficulties with Traveling:

__ driving a motor vehicle __ riding as a passenger in a motor vehicle

__ riding as a passenger on a train __ driving for long periods of time(> 1 hour)

__ flying on an airplane __ riding as a passenger for long periods (> 1 hour)

Activities of Daily Living Assessment (2/2)

Use the following **1-5** scale to describe the difficulties below:
1= “This area is not affected by my condition”
2= “This area is slightly affected by my condition”
3= “My condition moderately restricts my ability in this area”
4= “My condition seriously limits my ability in this area”
5= “My condition prevents me from using this ability”

Difficulties with Different Forms of Communication

__ concentrating __ hearing __ listening __ speaking __ reading__ writing __ typing

Difficulties with the Senses:

__ seeing __ hearing __ touch __ taste __ smell

Difficulties with Hand Functions:

__ grasping __ holding __ pinching __ percussive movements __ sensory discrimination

Difficulties with Sleep and Sexual Function:

__ being able to have normal, restful nights sleep

__ being able to participate in desired sexual activity

Write in below any additional information regarding your Activities of Daily Living. (that wasn’t covered above):

____

____

____

Prior Symptom History/ Prior Similar Symptoms:
__ I have NOT had prior symptoms similar to my current complaints.
__ My current complaints DID exist before, but have not been bothering me.
__ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?
__ My history HAS contributed to my current symptoms.
__ My history HAS NOT contributed to my current symptoms.
__ I’m NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred:
__ months ago, __ years ago. Or on Date: ____/____/_____

Write below any other Prior Symptom History, not covered

above:____

____

____

____
Patient Signature:

____
Michelle Paris, DC