Patient Health Questionnaire

Patient Name____ **Date**___________________________

1. Describe your current symptoms (Begin with what bothers you the most): ___________________________

____

2. Do your symptoms radiate (travel)? □ Yes □ No If yes, to what part of your body? ______________________

3. How long have your symptoms been present? ____

4. When is it most noticeable? □ Upon Waking □ During the day □ Afternoon □ Evening □ While Trying to sleep

____

5. What activities make your symptoms worse?
□ Ice □ Rest □ Sitting □ Medication
□ Heat □ Activity □ Standing □ ____________

____

6. What activities make your symptoms better?
□ Ice □ Rest □ Sitting □ Medication
□ Heat □ Activity □ Standing □ ____________

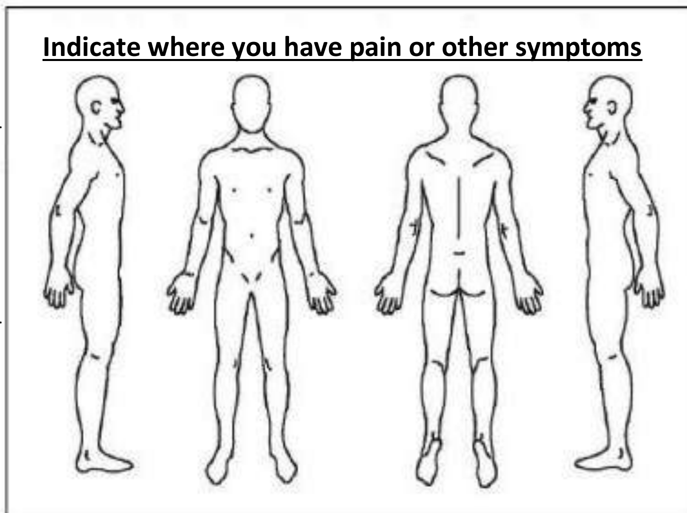
7. What describes the nature of your symptoms?
□ Sharp □ Shooting
□ Dull Ache □ Burning
□ Numb □ Tingling

____

8. How often are your symptoms present?
□ Occasional (0-25%) □ Frequent (50-75%)
□ Intermittent (25-50%) □ Constant (75-100%)

____

9. How are your symptoms changing?
□ Getting Better
□ Not Changing
□ Getting Worse



____

10. Who else have you seen for your current symptoms?
□ No One □ Medical Doctor □ This Office
Provider's name: ____________________ □ Other Chiropractor □ Physical Therapist □ ____________

____

11. What tests have you had for your symptoms? □ None □ MRI date: ____________
□ X-rays date :____________ □ CT Scan date: ____________

____

12. What describes the severity of your symptoms? **None 1 2 3 4 5 6 7 8 9 10 Severe**

____

13. What other forms of care have you tried for your current complaint?
□ Nothing □ Muscle Relaxer □ Advil / Tylenol / Aleve (circle) □ Injections
□ Pain Medication □ Ice / Heat (circle) □ Physical Therapy □ Other______________

____

14. What do you feel caused your symptoms? □ Fall □ Lifting □ Work
□ Car Accident □ Don't Know □ ________________

____

15.What activities are affected by your symptoms?
□ Work/School (circle) □ Sleeping □ Driving/Riding in Car (circle) □ Golf □ Exercising
□ Walking □ Running □ House Work □ Yard Work □ ________________

____

LE: CL:

For each of the conditions listed below, place a check in the* PAST *column if you have had the condition in the past.

Place a check in the* PRESENT *column if you currently have the conditions listed.

<u>Many of the following conditions respond to chiropractic and acupuncture</u>

16. 17.

PAST	PRESENT	
( )	( )	Headaches
( )	( )	Neck Pain
( )	( )	Upper Back Pain
( )	( )	Mid Back Pain
( )	( )	Low Back Pain
( )	( )	Scoliosis
( )	( )	Shoulder Pain
( )	( )	Elbow Pain
( )	( )	Wrist Pain
( )	( )	Hand Pain
( )	( )	Hip Pain
( )	( )	Knee Pain
( )	( )	Ankle Pain
( )	( )	Foot Pain
( )	( )	Jaw Pain/TMJ
( )	( )	Joint Swelling/Stiffness
( )	( )	Arthritis
( )	( )	Rheumatoid Arthritis
( )	( )	Lyme Disease
( )	( )	General Fatigue
( )	( )	Ringing in Ears
( )	( )	Visual Disturbances
( )	( )	Dizziness
( )	( )	Nausea

PAST	PRESENT	
( )	( )	High Blood Pressure
( )	( )	Low Blood Pressure
( )	( )	High Cholesterol
( )	( )	Heart Attack
( )	( )	Chest Pains
( )	( )	Stroke
( )	( )	Angina
( )	( )	Kidney Stones
( )	( )	Kidney Disorder
( )	( )	Bladder Infection
( )	( )	Painful Urination
( )	( )	Loss of Bladder Control
( )	( )	Prostate Problems
( )	( )	Reflux/Heartburn
( )	( )	Abnormal Weight Gain
( )	( )	Abnormal Weight Loss
( )	( )	Loss of Appetite
( )	( )	Constipation
( )	( )	Abdominal Pain
( )	( )	Ulcer
( )	( )	Hepatitis
( )	( )	Liver Disorder
( )	( )	Gall Bladder Disorder
( )	( )	Cancer
( )	( )	Tumor
( )	( )	Asthma
( )	( )	Chronic Sinusitis
( )	( )	Seasonal Allergies

PAST	PRESENT	
( )	( )	Diabetes
( )	( )	Excessive Thirst
( )	( )	Excessive Urination
( )	( )	Hypo-Thyroid
( )	( )	Hyper-Thyroid
( )	( )	Smoking/Tobacco Use
( )	( )	Drug/Opioid Dependence
( )	( )	Alcohol Dependence
( )	( )	Food Allergies
( )	( )	Depression
( )	( )	Anxiety
( )	( )	Frequent Illness
( )	( )	Epilepsy
( )	( )	Dermatitis
( )	( )	Eczema
( )	( )	Poison Ivy/Oak
( )	( )	HIV/AIDS

Females Only

PAST	PRESENT	
( )	( )	Hot Flashes
( )	( )	Hormone Replacement
( )	( )	Birth Control Pills
( )	( )	Painful Periods/Cramps

YES NO Are You Pregnant?

18. Primary Care Physician______________________________ **18b. Date of Last Medical Physical**____________________

19. 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: ___________

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

____

21. List all the surgical procedures you have had AND times you have been hospitalized (INLCUDING GIVING BIRTH):

____

____

22. <u>ANY & ALL LIFETIME TRAUMA HISTORY</u> to head, neck, or back (such as concussion, automobile accidents, sports injuries, work-related accidents, etc)...EVEN IF YOU DID NOT HAVE ANY SYMPTOMS OR TREATMENT, STILL NOTE THE TRAUMA PLEASE.

____

____

Patient Signature____ ***Date***__________________________

Patient Introduction Card

Today's Date ________________ Account #_______________

Full Legal Name ____ Prefer To Be Called___________________

Home Address____ Occupation_________________________

City_________________________ State_______ Zip____________ Employer____________________________

Home Phone_____________________________ Name of Insurance Co_________________

Cell Phone_________________________ ***Provider***_____________ Policy Holder Name __________________

Work Phone_____________________________ Policy Holder Date of Birth _____________

Email__________________________________ Primary Care Doctor__________________

Date of Birth__________________ Age______ Previous Chiropractic Care? ☐ YES ☐ NO

☐ Married ☐ Single ☐ Other___________ Major Complaint Today________________

Social Security #__________________________ ____________________________________

Preferred method of contact for appointment reminders ☐ Phone ☐ Email ☐ Either is fine

Who (or what source) referred you to our office? ____

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