Name:_____ Date:_____ Sex F M Age:_____ Telephone:_____

Address:_____ City:_____ Zip:_____ DOB:_____

email:_____ SS#:_____

1. Please Describe Your Complaint: _____

_____

_____

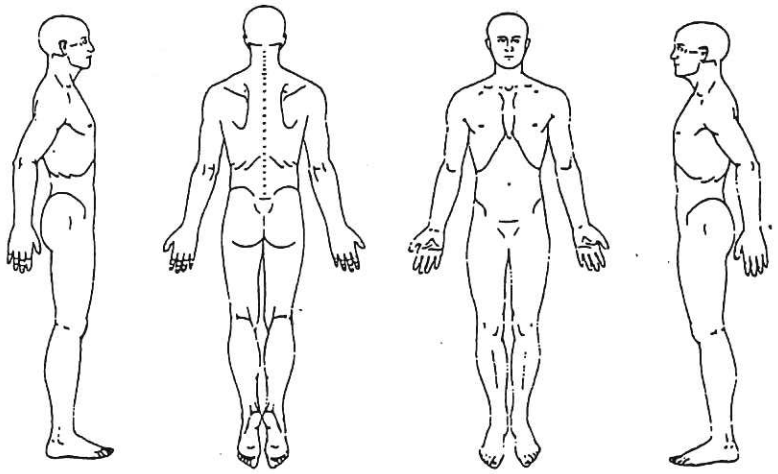
a. Description:

- ☐ 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 ☐ Increases during the day ☐ Same all day.

2. When did your problem 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 ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
   Are you currently being seen? ☐ Yes ☐ No
   When and what treatment? __/__/__ _____

_____

4. ***In the past*** have you been treated for the same or a similar problem? ☐ Yes ☐ No
   If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
   When and what treatment did you receive? _____

_____

5. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity
6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity
7. How would you rate your general stress level? ☐ Little or No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed
8. General Physical Activity: ☐ No regular exercise program ☐ Light exercise program ☐ Moderate exercise program ☐ Strenuous exercise program
9. Are your complaints affecting your ability to be active?
   - ☐ No effect
   - ☐ Need limited assistance with common everyday tasks.
   - ☐ Have a significant inability to function without assistance.
   - ☐ Some physical restrictions (able to perform light duty work and houshold tasks).
   - ☐ Need assistance often.
   - ☐ Am totally disabled (impaired). Cannot care for self.
10. Physical activity at work: ☐ Sitting more than 50% of workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion
11. Occupation: _____ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ YES ☐ NO
12. What is your current work status?
    - [1] Full time, no restrictions.
    - [2] Full time, with restrictions.
    - [3] Part time, no restrictions.
    - [4] Part time, with restrictions.
    - [5] Off work due to restrictions.
    - [6] Full time homemaker.
    - [7] Unemployed.
    - [8] Retired.
    - [9] Full time student.
    - [10] Other: _____

PLEASE CONTINUE ON PAGE 2

Marital Status:
Married____ Single ___
Widowed____ Divorced ___

Alternate Phone #_____

PATIENT HEALTH QUESTIONNAIRE

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)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(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)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	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 (by condition)
☐	☐	Colitis (558.9)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Systemic Lupus
☐	☐	Other_____

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

☐ Cancer
☐ Rheumatoid Arthritis
☐ Diabetes
☐ Heart Problems
☐ Lung Problems
☐ High Blood Pressure
☐ Epilepsy
☐ Chronic Back Problems
☐ Chronic Headaches
☐ Lupus
☐ Other Conditions _____

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location _____
☐	☐	Date rating received ___/___/___
		Rating Percentage _____%

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)
		_____
		_____
☐	☐	Hospitalization/Surgical Procedures (list if not described elsewhere) _____
		_____

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

STAFF

BP:_____/_____ Resp:[redacted]

Present: Weight _____ pounds **Height** ___ feet ____ inches

Patient's signature: _____ **Date:** ___/___/___

ALLERGIES:_____

_____

_____

_____

_____

Medications:(List with doses. Include supplements,vitamins, contraceptive, etc.)

_____

_____

_____

_____