PATIENT HEALTH QUESTIONNAIRE

Name _____ Date_____/_____/_____

In the space below, please describe your major complaint, if you have an additional complaint, please describe on page 2.

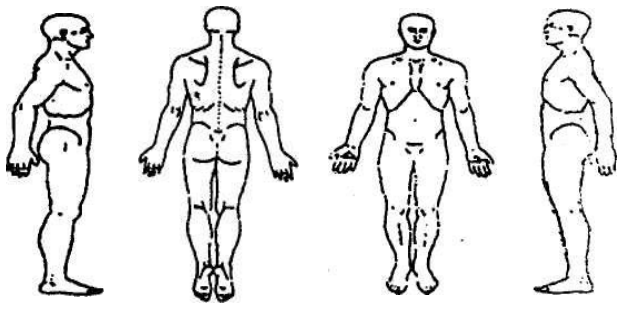
1. Please Describe Your Complaint: _____

_____

_____

MARK ON THE PICTURES BELOW WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:

a) Description
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning



b) Frequency
- ☐ Constant (78%-100%)
- ☐ Frequent (51%-75%)
- ☐ Occasional 25%-50%)
- ☐ Intermittent (25% or less)

c) Indicate Intensity of your Pain at its lowest and highest level: (Circle one)
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? _____/_____/_____

What treatment did you receive? _____

_____

_____

4. *In the past* have you been treated for the same or a similar problem? YES NO

When? _____/_____/_____

What treatment did you receive? _____

_____

_____

5. What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

What makes your problem worse? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

6. How would you rate your general stress level? Little or No stress Minimal stress Moderate stress Greatly Stressed

7. General Physical Activity: No regular exercise program Light exercise program Moderate exercise program Strenuous exercise program

8. Are your complaints attracting your ability to be active? No effect Some physical restrictions (able to perform light duty work & household tasks) Need limited assistance w/common everyday tasks Need Assistance often Have significant inability to function without assistance Am totally disabled (impaired) Cannot care for self

10. Physical activity at work: Sitting more than 50% of the workday Light manual labor Manual labor Heavy labor Repeated motion

11. Occupation: _____ Full Time Part Time Has your work status changed because of this complaint? YES NO

12. What is your current work status? Full Time/no restrictions Full Time/with restrictions Part Time/no restrictions Part Time/with restrictions Off work due to restrictions Full Time Homemaker Full Time Student Unemployed Retired Other

PLEASE CONTINUE ON PAGE 2

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 covering the past and the present conditions and diseases assist your doctor in more thoroughly **understanding your state of health.**

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in upper arm/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/hip (719.45)
☐	☐	Pain in lower leg/knee (729.5)
☐	☐	Pain in ankle/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)
☐	☐	Headaches (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Tinnitus (Ear noises) (388.30)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (788.50)
☐	☐	Loss of Appetite (783.0)
☐	☐	Anorexia (307.1)
☐	☐	Abnormal Weight Gain (783.1)
☐	☐	Abnormal Weight 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)

Past	Present	
☐	☐	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)
☐	☐	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 disorder (492.S)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Diabetes (250.0)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (558.9)
☐	☐	Liver (573.9)/
☐	☐	Gallbladder (575.9)
☐	☐	Kidney Stones (592.0)
☐	☐	Hepatitis (573.3)
☐	☐	Bladder Infection (595.9)
☐	☐	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:
☐	

Do you have a permanent disability rating? Yes ☐ No ☐

Location _____

Date rating received _____/_____/_____

Rating Percentage _____%

Please check any of the following that apply to you:

Past	Present	
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Hormone/Estrogen Replacement
☐	☐	Coffee/Tea/Caffeine Soft Drinks ( ) oz per day
		Hospitalizations/Surgical Procedures (List if not described elsewhere)
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Past	Present	
☐	☐	Tobacco (305.1)
☐	☐	Alcohol (305.0)
☐	☐	Drug or Alcohol Dependence
		Medications (List if not listed elsewhere)
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Present Weight: _____ lbs Height: _____ft _____in Age: _____ Date of Last X-Ray:_____

Patient's Signature: _____ Date: _____/_____/_____

Doctor's Additional Comments/General Health Concerns: _____

_____

Doctor's signature_____