Patient Health Questionnaire

Patient Name: _____ Date: _____/_____/_____

Describe your symptoms:

a. When did they start? _____/_____/_____

b. How did they begin? _____

_____

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)*

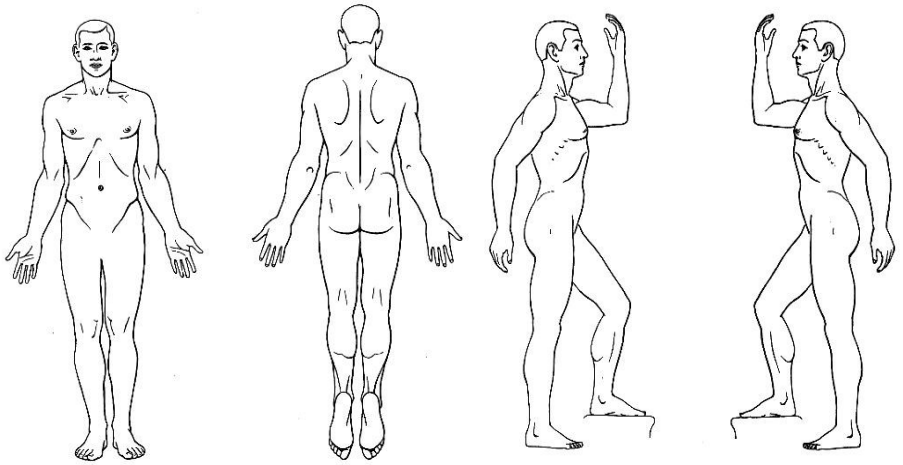
What describes the nature of your symptoms?

- ☐ *Sharp* ☐ *Shooting*
- ☐ *Dull Ache* ☐ *Burning*
- ☐ *Numb* ☐ *Tingling*

How are your symptoms changing?

- ☐ *Getting better*
- ☐ *Not changing*
- ☐ *Getting worse*

Indicate where you have pain or other symptoms



None 1 2 3 4 5 6 7 8 9 Unbearable

During the past 4 weeks:

a. Indicate the average intensity of your symptoms ———> ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

b. How much has pain interfered with your normal work (including both work outside the home and housework)

☐ *Not at all* ☐ *A little bit* ☐ *Moderately* ☐ *Quite a bit* ☐ *Extremely*

c. How much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

☐ *None of the time* ☐ *A little of the time* ☐ *Some of the time* ☐ *Most of the time* ☐ *All of the time*

Have you had surgery for this condition? ☐ *Yes (If yes), When?* ____/____/____ ☐ *No*

Where? _____

In general would you say your overall health right now is…

☐ *Excellent* ☐ *Very good* ☐ *Good* ☐ *Fair* ☐ *Poor*

Who have you seen for your symptoms? ☐ *No One* ☐ *Medical Doctor* ☐ *Other* ☐ *Chiropractor* ☐ *Physical Therapist*

a. What treatment did you receive and when? _____

b. What tests have you had for your condition and when were they performed? ☐ *Xrays date:* _____ ☐ *CT Scan date:* _____ ☐ *MRI date:* _____ ☐ *Other date:* _____

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* ☐ *Medical Doctor* ☐ *Other* ☐ *Chiropractor* ☐ *Physical Therapist*

What gives you relief?

1. _____
2. _____
3. _____
4. _____

What causes more pain?

1. _____
2. _____
3. _____
4. _____

What is your occupation? _____

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

☐ *Full-time* ☐ *Self-employed* ☐ *Off work*

☐ *Part-time* ☐ *Unemployed* ☐ *Other*

Please list all medications you are taking <u>for this condition:</u>

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you now have or have you ever had any of the following:

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Kidney Problems	☐	☐
Cardiac Conditions	☐	☐	Liver Problems	☐	☐
Heart Attack	☐	☐	Cancer	☐	☐
Circulation Problems	☐	☐	Claustrophobia	☐	☐
Pacemaker	☐	☐	Nervous Disorders	☐	☐
Seizures	☐	☐	Vision Problems	☐	☐
Dizzy Spells	☐	☐	Sensitivity to Heat	☐	☐
Diabetes	☐	☐	Sensitivity to Cold	☐	☐
Allergies	☐	☐	Speech Problems	☐	☐
Fractures	☐	☐	Metal Implants	☐	☐
Head Injury/Stroke	☐	☐	Are you pregnant?	☐	☐
Arthritis	☐	☐	Recent Eye Surgery?	☐	☐
Headaches?	☐	☐	Brittle Bones/Osteoporosis	☐	☐

When do you return to your <u>referring doctor</u> again? _____/_____/_____

Patient signature: _____ ***Date:*** _____