Patient Health Questionnaire

Healthy Family Chiropractic, PC.

ChiroCare Use Only rev 4/19/99

Patient Name ______________________ ***Date*** ______________________

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

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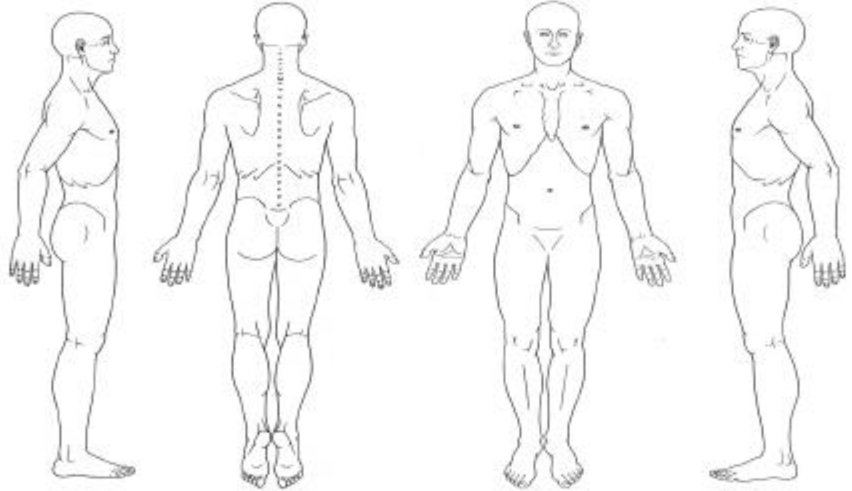
2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

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



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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Patient Name ______________________ **Date** ______________

Play any sports? ☐ **Yes** ☐ **No** **What sports?** ______________________

Ever broken a bone? ☐ **Yes** ☐ **No** **What bones?** ______________ **Knocked out?** ☐ **Yes** ☐ **No**

Falls as a child? ☐ **Yes** ☐ **No** **Explanation:** ______________________

Motor vehicle accidents? (please note type and year, even if not apparently injured) ______________

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

Past	Present	Condition
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	

Other Health Problems/Issues

Past	Present	Condition
☐	☐	
☐	☐	
☐	☐	

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

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Doctors Signature ______________________ **Date** ______________