# PATIENT HEALTH QUESTIONNAIRE

**Name** ________________________________ **Date** _______________ **Age**_________

**What problem or symptoms brought you here today?** ________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**When did your problem or symptoms begin?** ______________________________________

**Describe how your symptoms began.** ____________________________________________

_____________________________________________________________________________

**How often do you experience your symptoms?**
(Please circle)

1) Constantly (76-100% of the day)
2) Frequently (51-75% of the day)
3) Occasionally (26-50% of the day)
4) Intermittently (0-25% of the day)

**How are your symptoms changing?** (Please circle)

1) Getting Better
2) Not Changing
3) Getting Worse

**Pain Scale** – Please circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10
None Little Medium Severe

**What activities make your symptoms worse?** ______________________________________

**What activities make your symptoms better?** ______________________________________

_____________________________________________________________________________

**Does your pain travel from one area of your body to another area?** (Please circle.) Yes No

(If yes, please explain.) _______________________________________________________

**Have you seen another Doctor for your symptoms?** _________________________________

**Have you had similar symptoms in the past?** (Please Circle) Yes No

**What is your occupation?** ____________________________________________________

**What is your height?** _____________ **Weight?** ____________

**What type of regular exercise do you perform?** (Please describe.) ___________________________

_____________________________________________________________________________

**List all prescription and over-the-counter medications and nutrition/herbal supplements you are taking.** ______________________________________________________

_____________________________________________________________________________

# PATIENT HEALTH QUESTIONNAIRE

**Patient Name** ________________________________ **Date**_____________________

**List all of the surgical procedures you have had and the times you have been hospitalized.**

_____________________________________________________________________________

_____________________________________________________________________________

**Have you ever been treated by a Chiropractor?** (Please circle) Yes No

(If yes, please list previous Chiropractors.) ____________________________________________________________

**Indicate if an immediate family member has had any of the following.**

______Rheumatoid Arthritis ______Heart Disease ______Diabetes ______Cancer

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 | | Past | Present | |
|---|---|---|---|---|---|
| _____ | ____ | Headaches | _____ | _______ | Hypertension |
| _____ | ____ | Neck Pain | _____ | _______ | Heart Attack |
| _____ | ____ | Upper Back Pain | _____ | _______ | Chest Pains |
| _____ | ____ | Mid Back Pain | _____ | _______ | Stroke |
| _____ | ____ | Low Back Pain | _____ | _______ | Angina |
| _____ | ____ | Shoulder Pain | _____ | _______ | Kidney Stones |
| _____ | ____ | Elbow Pain | _____ | _______ | Kidney Disorders |
| _____ | ____ | Wrist Pain | _____ | _______ | Bladder Infection |
| _____ | ____ | Hand Pain | _____ | _______ | Painful Urination |
| _____ | ____ | Hip Pain | _____ | _______ | Loss of Bladder Control |
| _____ | ____ | Knee Pain | _____ | _______ | Prostate Problems |
| _____ | ____ | Ankle/Foot Pain | _____ | _______ | Abnormal Weight Gain/loss |
| _____ | ____ | Jaw Pain | _____ | _______ | Loss of Appetite |
| _____ | ____ | Arthritis | _____ | _______ | Ulcer |
| _____ | ____ | General Fatigue | _____ | _______ | Hepatitis |
| _____ | ____ | Dizziness | _____ | _______ | Liver/Gallbladder disorder |
| _____ | ____ | Cancer | _____ | _______ | Tumor |
| _____ | ____ | Asthma | _____ | _______ | Chronic Sinusitis |
| _____ | ____ | Diabetes | _____ | _______ | Excessive Thirst |
| _____ | ____ | Frequent Urination | _____ | _______ | Smoking/Tobacco Products |
| _____ | ____ | Drug/Alcohol Dependence | _____ | _______ | Allergies |
| _____ | ____ | Depression | _____ | _______ | Systemic Lupus |
| _____ | ____ | Dermatitis/Eczema/Rash | _____ | _______ | HIV/AIDS |
| _____ | ____ | Birth Control Pills | _____ | _______ | Hormonal Replacement |

**Other Health Problems** ____________________________________________________________

**Patient Signature** ______________________________ **Date** ___________________