Patient Health Questionnaire

PATIENT NAME: _____ DATE:_____

1. Describe your symptoms:

When did your symptoms start?

How did your symptoms begin?

2. How often do you experience your symptoms? Constantly / Frequently / Occasionally / Intermittently

3. What describes the nature of your symptoms? Sharp / Dull Ache / Numb / Shooting / Burning / Tingling

4. How are your symptoms changing? Getting Better / Not Changing / Getting Worse

5. During the first 4 weeks:

5a. Indicate the average intensity of your symptoms:

1 being NONE and 10 being UNBEARABLE

0 1 2 3 4 5 6 7 8 9 10

5b. How much has pain interfered with your normal day? Not at all / A little bit / Moderately / Quite a bit / Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

7. In general would you say your overall health is... Excellent / Very Good / Good / Fair / Poor

8. Have you seen any other MDs for your symptoms? No One Chiropractor Medical Dr Physical, Therapist, Other If so who?

9. Have you had similar symptoms in the past? Yes / No

10. If you have received treatment in the past for the same or similar symptoms, who did you see?

11. What is your occupation?

12. If you are not retired, a homemaker, or a student, what is your current work status? Indicate where you have pain or other symptoms:

Please rate your current pain (1 being NONE and 10 being UNBEARABLE)

1 2 3 4 5 6 7 8 9 10

CONTINUE ON NEXT PAGE

Health Questionnaire 2

1. Are you being treated for any medical condition? Yes / No

2. Are you taking any pain medications, blood thinners, etc? Yes / No

3. Do you have any allergies? Latex / Rubber

4. Do you have or have you had any heart related problems? Yes / No

5. Do you have a prosthetic or artificial joint? Yes / No

6. Do you have a bleeding problem or bleeding disorder? Yes / No

7. Are you pregnant? Yes / No How far along? _____

8. Do you have any sensitivity to heat and/or cold? Yes / No

9. Do you have any lack of sensation? Yes / No List all medications currently taking:_____
_____
_____
_____

Recent surgeries:
_____
_____
_____
_____
_____
_____

Medical Health History

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode? Yes / No
Chiropractor? Yes / No
General Practitioner? Yes/No
EMG/NCV? Yes/No CT Scan? Yes/No
Massage Therapy? Yes/No MRI? Yes/No
Myelogram? Yes/No
Neurologist? Yes/No
Occupational Therapy? Yes/No
Orthopedist? Yes/No
Physical Therapy? Yes/No
Podiatrist? Yes/No
Emergency Room? Yes/No
X-Rays? Yes/No
CONTINUE ON NEXT PAGE
Health Questionnaire 3
Do you now or have you ever had any of the following?
Asthma? Yes/No
Bronchitis? Yes/No
Emphysema? Yes/No High
Blood Pressure? Yes/No
Anemia? Yes/No
Shortness of Breath/Chest Pain? Yes/No
Heart Attack or Surgery? Yes/No Diabetes? Yes/No
Coronary Heart Disease or Angina? Yes/No
Thyroid Trouble/Goiter? Yes/No
Gout? Yes/No

Cancer/chemotherapy/Radiation? Yes/No
Dizziness or Fainting? Yes/No
Vertigo? Yes/No
Weakness? Yes/No
Emotional/Psychological? Problems Yes/No
Infectious Diseases? Yes/No Hernia? Yes/No
Bowel or Bladder Problems? Yes/No
Numbness or Tingling? Yes/No Allergies? Yes/No
Severe or Frequent Headaches? Yes/No
Migraines? Yes/No Elbow/Hand Injury? Yes/No
Osteoporosis? Yes/No
Vision or Hearing Difficulties? Yes/No
Neck Injury/Surgery? Yes/No
Stroke/TIA? Yes/No
Sleeping Problems/Difficulties? Yes/No
Back Injury/Surgery? Yes/No
Blood Clot/Emboli? Yes/No
Leg/Ankle/Foot Injury/Surgery? Yes/No
Knee Injury/Surgery? Yes/No
Epilepsy/Seizures? Yes/No
Do you have a Pacemaker? Yes/No
Varicose Veins? Yes/No
Any Pins or Metal Implants? Yes/No
Are You Pregnant? Yes/No
Joint Replacement? Yes/No
Weight Loss/Energy Loss? Yes/No
Do You Smoke? Yes/No

The following information is required to enable us to provide you with the best possible care. All information is strictly private, and is protected by doctor-patient confidentiality. The physical therapist will review the questions and explain any that you do not understand. Thank you.

Patient Signature: _____ DATE:_____