Patient Health Questionnaire

*Patient Name*_____ *Today's Date* ____/____/____

*DOB*_____ *Age*_____ *Phone: (H)*_____*(C)*_____

*Email Address:*_____

*Address:*_____

*City:*_____*State:*_____*Zip:*_____

*Sex: Male Female Marital Status: Single Married/Partnered Widowed Divorced Other:*_____

Children: Yes No How many? _____*Social Security#*_____ *Occupation:*_____

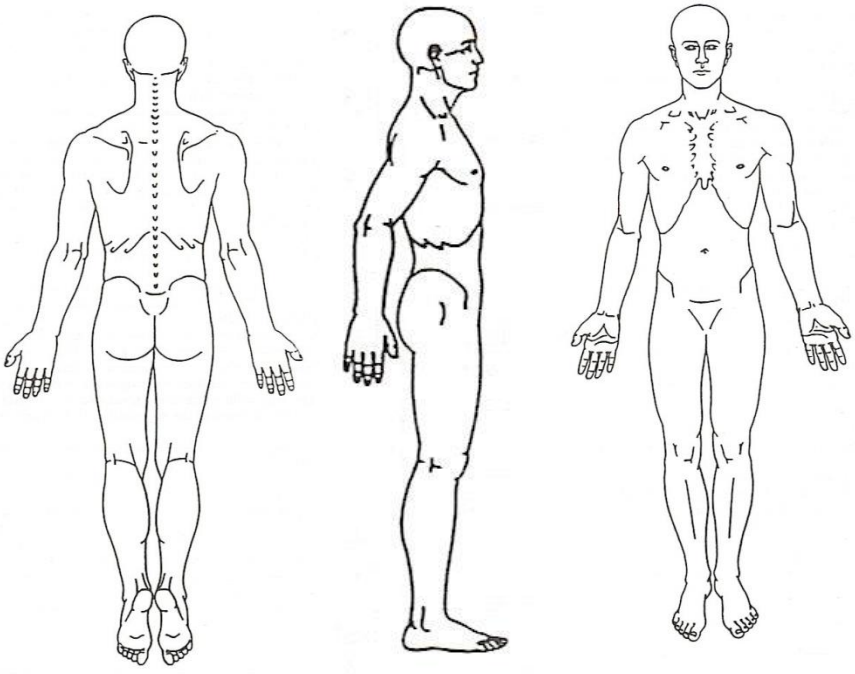
*EmployerName/Address:*_____

_____

*Office Phone*_____ *Office Fax*_____*Other:*_____

*How did you hear about our office?*_____

1. Please indicate for which body region you are seeking treatment (circle):
*Neck Shoulder Elbow Low Back Middle Back Hip Knee Ankle/Foot TMJ Other:*_____



Please mark the diagram to the left using the letters below to describe your complaints

P= Sharp Pain	*N = Numbness*
B = Burning	*R = Radiating*
W =Weakness	*T = Tingling*
D = Dull Ache	*S = Stiff/Sore*

*ADDITIONAL NOTES or COMPLAINTS:*_____

_____

_____

_____

_____

_____

_____

_____

_____

*2. When did your symptoms begin?*_____

*3. How often do your symptoms occur? Occasional Intermittent Frequent Constant Other:*_____

4. Using a scale of 0-10 (10 being extreme) how would you rate your pain? ___ At present ____ At best ____ At worst

5. What activities/positions aggravate your condition? _____

_____

6. What activities/positions relieve your condition? _____

_____

*7. Have you had any treatment associated with this condition? (Ex. OTC medications, physical therapy, massage, chiropractic care) If so please list dates, treatments and doctors:*_____
_____

8. Have you noticed changes in your bladder, bowel or sexual function since your symptoms began? Yes No
*If yes, describe*_____

9. Have you ever had any of the following? (Please check all that apply)
☐Anxiety disorder ☐Depression ☐Heart problems ☐Headaches ☐Nausea ☐Arthritis ☐Diabetes ☐Hernia ☐Osteoporosis ☐Strokes ☐Bladder problems ☐Dizziness ☐High blood pressure ☐Pacemaker ☐Sweating ☐Blood clots ☐Easy bleeding ☐HIV/AIDS ☐Pregnancy ☐Ulcers ☐Bowel problems ☐Emphysema ☐Kidney problems ☐Rheumatoid ☐Vomiting ☐Broken bones ☐Fatigue ☐Liver/Gallbladder ☐Ringing in ears ☐Weakness ☐Cancer ☐Fever ☐Major trauma ☐Seizures ☐Weight gain ☐Chills ☐Head injury ☐Metal implants ☐Skin problems ☐Weight loss ☐Circulatory problems ☐Allergies (please list below):
_____

10. Please indicate whether you are RIGHT or LEFT handed: _____

11. What are your habits?

Smoking:	*Never Socially Often*	*How many packs a day?*_____
Alcohol:	*Never Socially Often*	*How many drinks a day?*_____
Caffeinated Drinks:	*Never Socially Often*	*How many glasses a day?*_____
Exercise:	*Never Occasionally Often*	*How many days a week?*_____
Drug/Substance Abuse:	*Never If yes, please discuss with the doctor.*	

11. Do you have a Primary Care Doctor or Chiropractor? Yes No Doctors name and address: _____
_____

*12. Have you been hospitalized in the past five years? Date and reason:*_____

*13. Have you had surgery in the past five years? Date and reason:*_____

*14. Have you had a serious accident in the past five years? Please describe:*_____

15. To your knowledge are you currently pregnant or trying to get pregnant? Yes No
_____

*16. Are you currently taking any medications including vitamins, supplements or OTC drugs? Yes No Please list medications and for what condition you are taking them:*_____
_____

17. What are your goals while receiving treatment in our office and the time frame:
_____
_____

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature_____Date___/____/____